Dental Registration and History

PATIENT INFORMATION

Date: ______________________________

Patient Name: ____

Prefer to be called: ______________________________________

Address: ____

City: ____

State: _____________________Zip: [enter]_________________

E-mail: ____

Sex: ☐Male ☐Female Date of Birth:[dob]________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐Separated ☐ Divorced ☐ Partnered

Patient Employer/School: _________________________________

Occupation: ____

Employer Address: _____________________________________

Spouse/Partner Name: ___________________________________

Birthdate: [spouse d.o.b.]_________________________________

Who may we thank for referring you?

____

DENTAL INSURANCE

Who is responsible for this account? [list name below]

Name: ____

Relationship to patient:☐ Self ☐ Spouse ☐ Partner ☐Dependent

Insurance Company: ______________________________

Group #: ______________________________

Is patient covered by additional insurance? ☐Yes ☐ No

Subscriber's Name: _______________________________

Birthdate: __________________ SS#: _______________

Relationship to patient: ☐ Self ☐Spouse ☐ Partner ☐Dependent

Insurance Company: ______________________________

Group # ______________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I understand that I am responsible for all costs of dental treatment. I also authorize Audrey Lower DMD LLC or insurance company to release any information required to process my claims.

______________________________ _______________
Patient/Guardian signature Date

PHONE NUMBERS

Phone: ______________________ Work: _______________________ Cell: ______________________________

Best time and number to reach you: _______________________________ Can we Contact you at work? ☐Yes ☐ No

IN CASE OF EMERGENCY, CONTACT:.

Name: ______________________________ Relationship: ____

Phone: _________________________ Work: __________________________ Cell: ___________________________

DENTAL HISTORY

Reason for today's visit: ________________________
____
Former Dentist: ______________________________
Address: ____________________________________
Date of last dental visit: ____________________
Date of last dental x-rays: ___________________

Place a mark on "yes" or "no" to indicate
If you have had or have any of the following:

Bad Breath	☐Yes☐ No
Bleeding gums	☐Yes ☐ No
Blisters on lips or mouth	☐Yes ☐ No
Burning sensation on tongue	☐Yes ☐ No

Chew on one side of mouth	☐Yes ☐ No
Cigarette, pipe, cigar smoking or chewing tobacco	☐Yes ☐ No
Clicking or popping jaw	☐Yes ☐ No
Dry mouth	☐Yes ☐ No
Fingernail biting	☐Yes ☐ No
Food collection between teeth	☐Yes ☐ No
Grinding teeth	☐Yes ☐ No
Gums swollen or tender	☐Yes ☐ No
Gum treatment	☐Yes ☐ No
Jaw pain or tiredness	☐Yes ☐ No
Lip or cheek biting	☐Yes ☐ No
Loose teeth	☐Yes ☐ No
Mouth breathing	☐Yes ☐ No

Mouth pain, brushing	☐Yes ☐ No
Orthodontic treatment	☐Yes ☐ No
Pain around ear	☐Yes ☐ No
Sensitivity to cold	☐Yes ☐ No
Sensitivity to heat	☐Yes ☐ No
Sensitivity to sweets	☐Yes ☐ No
Sensitivity when biting	☐Yes ☐ No
Sores or growths in mouth	☐Yes ☐ No

Flossing and Brushing :
How often do you floss? [# per week]____
How often do you brush? [# per day] ____

- -

Your current dental health is?	☐Good ☐Fair ☐Poor
Type of bristle on your toothbrush?	☐ Hard ☐Medium ☐Soft
Do you still have wisdom teeth?	☐Yes ☐ No
Would you like fresher breath?	☐Yes ☐ No
Are you happy with the way your smile looks?	☐Yes ☐ No
Would you like to discuss a smile makeover?	☐Yes ☐ No
Are you interested in having straighter teeth?	☐Yes ☐ No
Are you interested in cosmetic dentistry?	☐Yes ☐ No

If not what would you change? ____________________________
____

HEALTH HISTORY

Physician's Name: ____ Physician's Phone Number: ________________________________

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva, Zometa ☐Yes ☐No

Have you ever been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐Yes ☐No

Have you had any metal rods, pins or joint replacements? ☐Yes ☐No

Women: Are you pregnant? ☐Yes ☐No Number of Weeks: _________ Are you nursing? ☐Yes ☐No

Are you taking Birth Control Pills? ☐Yes ☐No

Medications:
List any medications you are currently taking and the correlating diagnosis: ____
____
____

Pharmacy Name: ____

Pharmacy Phone: ____

Do you have or have you ever had any of the following diseases or medical problems?

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions
☐	☐	Abnormal Bleeding	☐	☐	Fever Blisters	☐	☐	Sinus Problems
☐	☐	Acid Reflux	☐	☐	Frequent Headaches	☐	☐	Sleep Apnea/Snoring
☐	☐	Alcohol Abuse	☐	☐	HBP or HBP Medication	☐	☐	Staph Infection
☐	☐	Allergies	☐	☐	HIV + AIDS	☐	☐	Stroke/TIA
☐	☐	Anemia	☐	☐	HPV Virus	☐	☐	Thyroid Problems
☐	☐	Angina Pectoris	☐	☐	Heart Murmur	☐	☐	Tuberculosis
☐	☐	Arthritis	☐	☐	Heart Surgery			
☐	☐	Artificial Bones	☐	☐	Hemophilia			
☐	☐	Artificial Heart Valve	☐	☐	Hepatitis A			
☐	☐	Asthma	☐	☐	Hepatitis B			
☐	☐	Blood Transfusion	☐	☐	Hepatitis C			
☐	☐	Cancer-Chemotherapy	☐	☐	Infect. Endocarditis			
☐	☐	Colitis	☐	☐	Kidney Problems			
☐	☐	Congenital Heart Defect	☐	☐	Liver Disease			
☐	☐	Diabetes	☐	☐	Low Blood Pressure			
☐	☐	Difficulty Breathing	☐	☐	Osteoporosis			
☐	☐	Drug Abuse	☐	☐	Osteoporosis Medicine			
☐	☐	Dry Mouth	☐	☐	Pace Maker			
☐	☐	Eating Disorder	☐	☐	Psychiatric Problems			
☐	☐	Emphysema	☐	☐	Radiation Therapy			
☐	☐	Epilepsy	☐	☐	Seizures			
☐	☐	Fainting Spells	☐	☐	Shingles			

ALLERGIES:

Y	N	
☐	☐	ASPIRIN
☐	☐	CODEINE
☐	☐	DENTAL ANESTHETICS
☐	☐	ERYTHROMYCIN
☐	☐	JEWELRY
☐	☐	LATEX
☐	☐	METALS
☐	☐	PENICILLIN
☐	☐	TETRACYCLINE

OTHER:[LIST OTHER ALLERGIES]

____

____

Any disease, condition, or problem not listed above? [Comments]

____

COMMUNICATION PREFERENCES
REGARDING PROTECTED HEALTH INFORMATION

TO ASSIST IN YOUR CARE, IT MAY BE NECESSARY TO RELEASE YOUR PROTECTED HEALTH INFORMATION TO SOMEONE OTHER THAN YOURSELF. TO WHOM MAY WE TALK?

Y	N	PLEASE LIST NAMES BELOW:
☐	☐	SPOUSE ____
☐	☐	PARENT ____
☐	☐	STEP-PARENT ____
☐	☐	CAREGIVER _____________________________________
☐	☐	OTHER PERSON (NAME) ______________________________ (RELATION TO PATIENT) ________________________

MAY WE LEAVE A MESSAGE ON:

Y	N	
☐	☐	YOUR ANSWERING MACHINE/VOICE MAIL AT HOME
☐	☐	YOUR VOICE MAIL AT WORK
☐	☐	YOUR CELL PHONE VOICE MAIL
☐	☐	MAY WE TEXT YOU?
☐	☐	MAY WE CONTACT YOU BY EMAIL? PREFERRED EMAIL ADDRESS: ____

____ __________________________________

PATIENT OR REPRESENTATIVE SIGNATURE ***(SIGN AFTER PRINTING FORM)*** DATE

____

PRINT NAME