

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date: _____ SS#: _____

Patient's Name: _____

Address: _____

Phone #: Hm# (____) _____ Work: (____) _____ Cell: _____

Sex: M F Single Married Widowed Separated Divorced

Age _____ Birthday _____

Occupation _____ Employer _____

Employer Phone# (____) _____

Spouse's Name: _____ Birthday: _____ SS#: _____

Occupation: _____ Spouse's Employer: _____

Spouse's Work #: _____ Spouse's Cell #: _____

Emergency Contact: _____ Relationship: _____
(Please specify someone who does not live in your household)

Home # _____ Cell# _____

Whom may we thank for referring you to our office? _____

Please Note:

DENTAL HISTORY

Patient's name: _____ Reason for today's visit: _____

Former Dentist: _____ City/State: _____

Date of last dental visit: _____ Date of last dental X- rays: _____

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

| | | | |
|-------------------------------|--|--------------------------------|--|
| Bad breath | <input type="checkbox"/> yes <input type="checkbox"/> no | Bleeding gums | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Blisters on lips or mouth | <input type="checkbox"/> yes <input type="checkbox"/> no | Burning sensation on tongue | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Chew on side of mouth | <input type="checkbox"/> yes <input type="checkbox"/> no | Cigarette, pipe, cigar smoking | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Clicking or popping jaw | <input type="checkbox"/> yes <input type="checkbox"/> no | Fingernail biting | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Food collection between teeth | <input type="checkbox"/> yes <input type="checkbox"/> no | Foreign objects | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Grinding teeth | <input type="checkbox"/> yes <input type="checkbox"/> no | Gums swollen or tender | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Jaw pain or tiredness | <input type="checkbox"/> yes <input type="checkbox"/> no | Lip or cheek burning | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Loose teeth/broken fillings | <input type="checkbox"/> yes <input type="checkbox"/> no | Mouth breathing | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Mouth pain, brushing | <input type="checkbox"/> yes <input type="checkbox"/> no | Orthodontic treatment | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Pain around ear | <input type="checkbox"/> yes <input type="checkbox"/> no | Periodontal treatment | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Sensitivity to cold | <input type="checkbox"/> yes <input type="checkbox"/> no | Sensitivity to heat | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Sensitivity to sweets | <input type="checkbox"/> yes <input type="checkbox"/> no | Sensitivity when biting | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Sores or growths in mouth | <input type="checkbox"/> yes <input type="checkbox"/> no | How often do you floss? _____ | |
| | | How often do you brush? _____ | |

HEALTH HISTORY

Patient's Name: _____

Physician's Name: _____ Date of last visit: _____

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of Phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramine). yes no

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

- | | | |
|--|--|--|
| Aids/HIV <input type="checkbox"/> yes <input type="checkbox"/> no | Emphysema <input type="checkbox"/> yes <input type="checkbox"/> no | Radiation Treatment <input type="checkbox"/> yes <input type="checkbox"/> no |
| Anemia <input type="checkbox"/> yes <input type="checkbox"/> no | Epilepsy <input type="checkbox"/> yes <input type="checkbox"/> no | Respiratory Disease <input type="checkbox"/> yes <input type="checkbox"/> no |
| Arthritis, Rheumatism <input type="checkbox"/> yes <input type="checkbox"/> no | Fainting or dizziness <input type="checkbox"/> yes <input type="checkbox"/> no | Rheumatic Fever <input type="checkbox"/> yes <input type="checkbox"/> no |
| Artificial Heart Valves <input type="checkbox"/> yes <input type="checkbox"/> no | Glaucoma <input type="checkbox"/> yes <input type="checkbox"/> no | Scarlet Fever <input type="checkbox"/> yes <input type="checkbox"/> no |
| Artificial joints <input type="checkbox"/> yes <input type="checkbox"/> no | Headaches <input type="checkbox"/> yes <input type="checkbox"/> no | Shortness of Breath <input type="checkbox"/> yes <input type="checkbox"/> no |
| Asthma <input type="checkbox"/> yes <input type="checkbox"/> no | Heart Murmur <input type="checkbox"/> yes <input type="checkbox"/> no | Sinus Trouble <input type="checkbox"/> yes <input type="checkbox"/> no |
| Back problems <input type="checkbox"/> yes <input type="checkbox"/> no | Heart Problems <input type="checkbox"/> yes <input type="checkbox"/> no | Skin Rash <input type="checkbox"/> yes <input type="checkbox"/> no |
| Bleeding abnormally with extractions or surgery <input type="checkbox"/> yes <input type="checkbox"/> no | Hepatitis Type <input type="checkbox"/> yes <input type="checkbox"/> no | Special Diet <input type="checkbox"/> yes <input type="checkbox"/> no |
| Blood Disease <input type="checkbox"/> yes <input type="checkbox"/> no | Herpes <input type="checkbox"/> yes <input type="checkbox"/> no | Snoring <input type="checkbox"/> yes <input type="checkbox"/> no |
| Cancer <input type="checkbox"/> yes <input type="checkbox"/> no | High Blood Pressure <input type="checkbox"/> yes <input type="checkbox"/> no | Stroke <input type="checkbox"/> yes <input type="checkbox"/> no |
| Chemical Dependency <input type="checkbox"/> yes <input type="checkbox"/> no | Jaundice <input type="checkbox"/> yes <input type="checkbox"/> no | Swollen Feet or Ankles <input type="checkbox"/> yes <input type="checkbox"/> no |
| Chemotherapy <input type="checkbox"/> yes <input type="checkbox"/> no | Jaw Pain <input type="checkbox"/> yes <input type="checkbox"/> no | Swollen Neck Glands <input type="checkbox"/> yes <input type="checkbox"/> no |
| Circulatory Problems <input type="checkbox"/> yes <input type="checkbox"/> no | Kidney Disease <input type="checkbox"/> yes <input type="checkbox"/> no | Thyroid Problems <input type="checkbox"/> yes <input type="checkbox"/> no |
| Congenital Heart Lesion <input type="checkbox"/> yes <input type="checkbox"/> no | Liver Disease <input type="checkbox"/> yes <input type="checkbox"/> no | Tonsillitis <input type="checkbox"/> yes <input type="checkbox"/> no |
| Cortisone Treatment <input type="checkbox"/> yes <input type="checkbox"/> no | Low Blood Pressure <input type="checkbox"/> yes <input type="checkbox"/> no | Tuberculosis <input type="checkbox"/> yes <input type="checkbox"/> no |
| Cough, persistent or bloody <input type="checkbox"/> yes <input type="checkbox"/> no | Mitral Valve Prolapse <input type="checkbox"/> yes <input type="checkbox"/> no | Tumor or Growth on head or neck <input type="checkbox"/> yes <input type="checkbox"/> no |
| Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no | Nervous Problems <input type="checkbox"/> yes <input type="checkbox"/> no | Ulcer <input type="checkbox"/> yes <input type="checkbox"/> no |
| | Pacemaker <input type="checkbox"/> yes <input type="checkbox"/> no | Venereal Disease <input type="checkbox"/> yes <input type="checkbox"/> no |
| | Psychiatric Care <input type="checkbox"/> yes <input type="checkbox"/> no | Weight Loss, unexplained <input type="checkbox"/> yes <input type="checkbox"/> no |

Do you wear contact lenses? yes no

WOMEN

Are you pregnant? yes no

Due Date: _____ Are you nursing? yes no

Taking birth control pills? yes no

MEDICATIONS

List any medications you are currently taking on a daily basis and the correlating diagnosis:

IF NONE PLEASE CHECK THIS BOX

ALLERGIES

- | | |
|---|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | <input type="checkbox"/> None |

I give my consent for initial treatment which may include exam, x-rays, impressions, photo's or emergency treatment as described to me by Dr. Murphy. Every reasonable effort will be made to ensure that my condition is treated properly. By signing below I acknowledge that I have received adequate information about the proposed treatment, and that I understand this information and that all of my questions have been answered.

Patient's Signature **X** _____

Doctor's Signature **X** _____

Date: _____

UPDATES (TO BE FILLED IN AT FUTURE APPOINTMENTS)

Has there been any change in your health since your last appointment? Yes No

For what condition? _____

Are you taking any medication now? _____ If so what for? _____

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

| Date | Changes | Patient's Signature X | Reviewed by |
|------|-------------------------------|------------------------------|-------------|
| Date | None <input type="checkbox"/> | | Dr. |
| Date | None <input type="checkbox"/> | | Dr. |

Dental Insurance

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Co: _____

Group #: _____

Is patient covered by additional insurance? = Yes = No

Subscriber's Name: _____

Birthday: _____ SS#: _____

Relationship to Patient: _____

Insurance Co: _____

Group #: _____

ASSIGNMENT & RELEASE

I the undersigned certify that I (or my dependent) have insurance coverage with

And assign directly to Dr. Carole Murphy all insurance benefits, if any.

Otherwise payable to me for services rendered. I understand that **I am financially responsible for all charges whether or not paid by insurance.** Any additional fees for collections will be the responsibility of the guarantor at a rate of 29%. Please initial **X** _____ I hereby authorize the doctor to release the use of this signature on all insurance admissions.

X _____

Responsible Party Signature

Relationship

Date