DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

_____
City State Zip

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone # _____

Spouse's/Parents Name _____

Birthdate _____

SS# _____

Occupation _____

Spouse's/Parents Employer _____

Whom may we thank for referring you? _____

_____

DENTAL INSURANCE

PRIMARY INSURANCE

Insurance Company _____

Group # _____

Employer: _____

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

SECONDARY INSURANCE

Insurance Company _____

Group # _____

Employer: _____

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Kenneth E. Kay 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. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature / Relationship Date

FINANCIAL INFORMATION

Who is responsible for the account? _____

Relationship to Patient:

I understand that I am responsible for all charges.

Signature _____ Date _____

3. PHONE NUMBERS

Home _____ Work _____ Ext. _____ Cell _____ Spouse's/Parents Work _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

DENTAL HISTORY

Reason for today's visit _____

_____

Date of last dental x-rays _____

Place a mark on "Yes" or "No" to indicate if you have any of the following:

Bad Breath	☐ Yes	☐ No
Bleeding/tender gums	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Periodontal/gum treatment	☐ Yes	☐ No

How often do you brush? _____ floss? _____

Are you interested in any of the following dental treatment?

Whiter teeth (bleaching)	☐ Yes	☐ No
Replacing decayed or broken silver fillings with tooth colored fillings	☐ Yes	☐ No
Would you like to have any cosmetic changes in your teeth?	☐ Yes	☐ No

Describe briefly _____

_____

Describe any other dental problems or concerns _____

_____

_____

_____

HEALTH HISTORY

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

Are you under medical treatment now? ☐ Yes ☐ No If yes, for what? _____

Please check "Yes" or "No" to indicate if you have had any of the following:

Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Born with Heart Defects	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis Type_____	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
HIV Positive	☐ Yes	☐ No
Infective Endocarditis	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Pulmonary Shunt	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swelling of Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or growth on head or neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Weight Loss, Unexplained?	☐ Yes	☐ No
Are you taking any blood thinners?	☐ Yes	☐ No
Women Are you pregnant? Due Date_____	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No

List any other medical conditions you have _____

MEDICATIONS

List any medications you are currently taking.

_____

_____

_____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex (Gloves)
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand that I must give 24 hours notice of an appointment change in order to avoid a broken appointment fee of $35.00.

Patient's Signature: _____ Date: _____