DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Whom may we thank for referring you? ________________________

Date ____

Name: Last ____

First ____________________________ MI ____________

E-mail ____

Address ____

City ________________ State ______________ Zip ______________

Sex ☐ Male ☐ Female

Birthdate ________________________________ Age __________

Social Security Number ____________________________________

☐ Married ☐ Widowed ☐ Single

☐ Minor ☐ Separated ☐ Divorced

Patient Employer/School ____________________________________

Occupation ____

Who is your favorite musician or what is your favorite music genre?

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2 FINANCIAL/INSURANCE INFORMATION

Who is responsible for this account? __________________________

Relationship to Patient ____________________________________

Is Patient covered by dental insurance? ______________________

Insurance Company ____

Phone number____________________ Group # ______________

Subscriber Name ____

Subscriber ID # or SS # ____________________________________

Subscriber birthdate ____

Relationship to Patient ____________________________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ________________________________ (name of insurance) and assign directly to Dr. Spillers 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, or Guardian ______________________

Printed Name ____

Date ___________ Relationship to patient ______________________

3 CONTACT INFORMATION

Phone Number: Home (_______) ____________________ Cell (_______) ____________________ Work (_______) ____________________ Ext ______

Spouse's Cell (_______) ____________________ Best time and number to reach you ____

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

Name ____ Relationship ____

Phone Number: Home (_______) ____________________ Cell (_______) ____________________ Work (_______) ____________________ Ext ______

4 DENTAL HISTORY

Reason for today's visit ____________________

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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 ☐ Yes ☐ No

Bleeding gums ☐ Yes ☐ No

Blisters on lips or mouth ☐ Yes ☐ No

Cigarrette, pipe, or cigar smoking ☐ Yes ☐ No

Clicking or popping jaw ☐ Yes ☐ No

Dry mouth ☐ Yes ☐ No

Fingernail biting ☐ Yes ☐ No

Food collections between the teeth ☐ Yes ☐ No

Grinding teeth ☐ Yes ☐ No

Jaw pain or tiredness ☐ Yes ☐ No

Loose teeth or broken fillings ☐ Yes ☐ No

Pain around ear ☐ Yes ☐ No

Periodontal treatment ☐ Yes ☐ No

Sensitivity to cold ☐ Yes ☐ No

Sensitivity to sweets ☐ Yes ☐ No

Sensitivity when biting ☐ Yes ☐ No

Sores or growths in your mouth ☐ Yes ☐ No

If you could wave a magic wand, what would you change about your smile? ______________

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