

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 Susan R. Tikson D.D.S. 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarette, pipe, cigar smoking or chewing tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Food collection between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Gum treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flossing and Brushing :	
		Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? [# per week] _____	
		Loose teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? [# per day] _____	
		Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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

If not what would you change? _____

Would you like to discuss a smile makeover with Dr. Tikson? Yes No

Are you interested in having straighter teeth? Yes No

Are you interested in cosmetic dentistry? Yes No

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																																							
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems																																							
<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea/Snoring																																							
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	HBP or HBP Medication	<input type="checkbox"/>	<input type="checkbox"/>	Staph Infection																																							
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	HIV + AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA																																							
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	HPV Virus	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems																																							
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis																																							
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<div style="background-color: #4a90e2; color: white; text-align: center; padding: 5px; font-weight: bold;">ALLERGIES:</div> <table border="0" style="width: 100%;"> <thead> <tr> <th>Y</th> <th>N</th> <th></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>ASPIRIN</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>CODEINE</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>DENTAL ANESTHETICS</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>ERYTHROMYCIN</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>JEWELRY</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>LATEX</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>METALS</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>PENICILLIN</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>TETRACYCLINE</td> </tr> <tr> <td colspan="3">OTHER:[LIST OTHER ALLERGIES]</td> </tr> <tr> <td colspan="3">_____</td> </tr> <tr> <td colspan="3">_____</td> </tr> </tbody> </table>			Y	N		<input type="checkbox"/>	<input type="checkbox"/>	ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>	CODEINE	<input type="checkbox"/>	<input type="checkbox"/>	DENTAL ANESTHETICS	<input type="checkbox"/>	<input type="checkbox"/>	ERYTHROMYCIN	<input type="checkbox"/>	<input type="checkbox"/>	JEWELRY	<input type="checkbox"/>	<input type="checkbox"/>	LATEX	<input type="checkbox"/>	<input type="checkbox"/>	METALS	<input type="checkbox"/>	<input type="checkbox"/>	PENICILLIN	<input type="checkbox"/>	<input type="checkbox"/>	TETRACYCLINE	OTHER:[LIST OTHER ALLERGIES]			_____			_____		
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<input type="checkbox"/>	<input type="checkbox"/>	Artificial Bones	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia																																										
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<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B																																										
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C																																										
<input type="checkbox"/>	<input type="checkbox"/>	Cancer-Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Infect. Endocarditis																																										
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems																																										
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease																																										
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure																																										
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis																																										
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis Medicine																																										
<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker																																										
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<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy																																										
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Seizures																																										
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Shingles																																										

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:

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