Dr. Chandler H. Pleasant PleasantSmiles Dentistry **Dr. Susan M. Burton**

DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID #_____

Patient Name_____
Last Name

_____ _____
First Name Middle Initial

Address_____

E-mail _____

City _____

State_____Zip_____

Sex ☐ M ☐ F Age_____

Date of Birth_____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____)_____

Spouse's Name_____

Date of Birth_____

SS#_____

Spouse's Employer _____

Whom may we thank for referring you?_____

2 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: _____

Date of Birth: _____ SSN#_____

Relationship to Patient: _____

Insurance Co. _____

Group #: _____

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s). have insurance coverage with

_____and assign directly to
Name of Insurance Company

Dr. _____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that 1 am financially responsible tor 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(ies) and their agents tor the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent. Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____)_____ Work (_____)_____Ext. _____ Cell (_____)_____

Spouse's Work (_____)_____ Best time and place you reach you _____

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

Name _____ Relationship _____

Home (_____)_____ Work (_____)_____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date or last dental visit _____

Date or 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
Burning sensation on tongue	Yes	No
Chew on one side of mouth	Yes	No
Cigarette, pipe, or cigar smoking	Yes	No
Clicking or popping jaw	Yes	No
Dry mouth	Yes	No
Fingernail biting	Yes	No
Food collection between the teeth	Yes	No
Grinding teeth	Yes	No
Gums swollen or tender	Yes	No
Jaw pain or tiredness	Yes	No
Lip or cheek biting	Yes	No
Loose teeth or broken fillings	Yes	No
Mouth breathing	Yes	No
Mouth pain, brushing	Yes	No
Orthodontic treatment	Yes	No
Pain around ear	Yes	No
Periodontal treatment	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 your mouth	Yes	No

How often do you floss? _____

How often do you brush? _____

- OVER -

5 HEALTH HISTORY

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 (dexfenflurami11e). Yes No

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

AIDS/HIV	Yes	No	Circulatory Problems	Yes	No	Psychiatric Care	Yes	No
Anemia	Yes	No	Congenital Heart Lesions	Yes	No	Radiation Treatment	Yes	No
Arthritis, Rheumatism	Yes	No	Do you wear contact lenses?	Yes	No	Respiratory Disease	Yes	No
Artificial Heart Valves	Yes	No	Cortisone Treatments	Yes	No	Rheumatic Fever	Yes	No
Artificial Joints	Yes	No	Cough, persistent or bloody	Yes	No	Scarlet Fever	Yes	No
Asthma	Yes	No	Diabetes	Yes	No	Shortness of Breath	Yes	No
Back Problems	Yes	No	Emphysema	Yes	No	Sinus Trouble	Yes	No
Bleeding abnormally, with extractions or surgery	Yes	No	Epilepsy	Yes	No	Skin Rash	Yes	No
			Glaucoma	Yes	No	Special Diet	Yes	No
Blood Disease	Yes	No	Headaches	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Heart Murmur	Yes	No	Swollen Feet or Ankles	Yes	No
Chemical Dependency	Yes	No	Heart Problems	Yes	No	Swollen Neck Glands	Yes	No
Chemotherapy	Yes	No	Hepatitis Type _____	Yes	No	Thyroid Problems	Yes	No
			Herpes	Yes	No	Tonsillitis	Yes	No
			High Blood Pressure	Yes	No	Tuberculosis	Yes	No
			Jaundice	Yes	No	Tumor or growth on head or neck	Yes	No
			Jaw Pain	Yes	No	Ulcer	Yes	No
			Kidney Disease	Yes	No	Venereal Disease	Yes	No
			Liver Disease	Yes	No	Weight Loss. unexplained	Yes	No
			Low Blood Pressure	Yes	No			
			Mitral Valve Prolapse	Yes	No			
			Nervous Problems	Yes	No			
			Pacemaker	Yes	No			

WOMEN:

Are you pregnant? Yes No

Taking birth control pills? Yes No

Due Date: _____

Are you nursing? Yes No

HEALTH HISTORY

List any medications you are currently taking and the correlating diagnosis

_____

_____

Pharmacy Name_____

Phone (_____)_____

ALLERGIES

Aspirin	Local Anesthetic
Barbiturates (Sleeping pills)	Penicillin
Codeine	Sulfa
Iodine	Other _____
Latex	_____

6 UPDATES (To be filled in at future appointments)

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

For what conditions? _____

Are you taking any new medications? _____ If so, what?_____

Patient's signature _____ Date: _____

Doctor's signature _____ Date: _____

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

For what conditions? _____

Are you taking any new medications? _____ If so, what?_____

Patient's signature _____ Date: _____

Doctor's signature _____ Date: _____