PleasantSmiles Dentistry

Dr. Chandler H. Pleasant

# 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 lonimin, 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 | Due Date: _____ | Are you nursing? | Yes | No |
| Taking birth control pills? | 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: _____