KYRENE FAMILY DENTISTRY

DENTAL REGISTRATION & HISTORY

PATIENT INFORMATION

Date _____

Patient Name

_____

Last Name First Name Middle Initial

Preferred to be called:_____

Social Security Number _____-_____- _____

E-mail _____

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birth date__ _____

☐ Married ☐ Widowed ☐ Single

☐ Separated ☐ Divorced ☐Minor

Patient Employer _____

Occupation _____

Employer Address _____

City _____ State _____ Zip _____

Employer Phone (_____) _____-_____ EXT:_____

Spouse's Name _____

Birth date _____

SS# _____-_____-_____

Spouse's Employer _____

How did you hear about us? (Check one only)

☐ Sidewalk Sign ☐Insurance Plan ☐Online Search

☐Referred by a friend/relative ☐ other _____

If you were referred, whom may we thank for referring you?

_____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Subscriber's Name _____

Insured birth date _____ SS# _____-_____-_____

Insurance Co. _____

Insurance Phone # _____

Group # _____ ID # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign

Name of Insurance Company(ies)

directly to Dr. _____ 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 (ies) and their agents for 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.

X_____

Signature of Patient or Parent/Guardian

_____

Please print the name of Patient or Parent/Guardian

_____ _____

Date Relationship to Patient

Phone Numbers

Home (____) _____-_____ Work (____) _____-_____ Ext _____ Cell phone (____) _____-_____

Spouse's Work (____) _____-_____ Best time & place to reach you _____

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

Name _____ Relationship _____

Home (____) _____-_____ Cell (____) _____-_____ Work (____) _____-_____

Dental History

Reason for today's visit_____

_____

Former Dentist _____

City/State_____

Date of last dental visit _____

Date if last dental x-rays_____

Mark on "yes" or "no to indicate if you had any of the following:

Bad breath ☐ Yes ☐No

Bleeding gums ☐ Yes ☐No

Lip or cheek biting☐ Yes ☐No

Dry 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

Periodontal treatment ☐ Yes ☐No

Fingernail biting ☐ Yes ☐No

Food collection between teeth ☐ Yes ☐No

Gums swollen or tender ☐ Yes ☐No

Jaw pain or tiredness ☐ Yes ☐No

Blisters on lips or mouth ☐ Yes ☐No

Sore or growths in your mouth ☐ Yes ☐No

Mouth breathing ☐ Yes ☐No

Mouth pain, brushing ☐ Yes ☐No

Orthodontic treatment ☐ Yes ☐No

Pain around ear ☐ Yes ☐No

Grinding Teeth ☐ Yes ☐No

Sensitivity to heat ☐ Yes ☐No

Sensitivity to cold ☐ Yes ☐No

Sensitivity to sweets ☐ Yes ☐No

Sensitivity when biting ☐ Yes ☐No

How often do you brush? _____

How often do you floss? _____

Health History

Physician's Name_____ Date of last visit _____

Have you ever taken of 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 (dexfenfluramine). ☐ Yes ☐No

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

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

Please list any other surgeries or medical conditions you have or ever had: _____

_____

Do you wear contact lenses? ☐ Yes ☐No **Women:** Are you pregnant? ☐ Yes ☐No Due Date:_____

Are you nursing? ☐ Yes ☐No Taking birth control pills? ☐ Yes ☐No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____Phone (___) ____-_____

Allergies

☐Aspirin ☐ Local Anesthetic ☐ Penicillin

☐Codeine ☐ Sulfa ☐ Iodine

☐Latex ☐Barbiturates (sleeping pills)

☐Other _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ **Date:** _____

NOTICE TO ALL PATIENTS

We reserve appointment time to properly serve you and our other patients. If you are not able to keep your appointment please contact us 24 hours in advance to avoid a cancellation fee of $25.00 per appointment hour. This advanced notice allows us the opportunity to serve other patient by placing them into the time slot. Thank You.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT _____ **Date**_____

Medical History Updates (To be filled in at future appointments)

Date: _____ Comments: _____ Initials: _____

Date: _____ Comments: _____ Initials: _____

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Have there been any changes 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: