



Sandra Embree^{DDS}

PLLC
FAMILY & COSMETIC DENTISTRY

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DENTAL REGISTRATION AND HISTORY

1. PATIENT INFORMATION

Date _____ SS# _____
 Patient _____
 Preferred Name _____
 Address _____
 City _____ Zip _____
 Sex M F Age _____ Birth Date _____
 Single Married Partner
 Occupation _____
 Employer _____
 Employer Address _____
 Employer Phone (_____) _____
 Spouse/Partner's Name _____
 Birth Date _____ SS# _____
 Occupation _____
 Spouse/Partner's Employer _____
 Whom may we thank for referring you? _____

2. PHONE NUMBERS

Home (_____) _____
 Work (_____) _____ Ext _____
 Cell Phone (_____) _____
 Pager (_____) _____ Ext _____
 E-Mail _____
 Best Time and Place to reach you _____

Prefer confirmation of appointments by:

E-mail Phone Both

IN CASE OF EMERGENCY, CONTACT:

(Specify someone who does not live in your household)

Name _____
 Relationship _____
 Home Phone (_____) _____
 Work Phone (_____) _____

3. INSURANCE

PRIMARY DENTAL INSURANCE

Name of Insured _____ LAST NAME FIRST NAME INITIAL Is insured a patient? Yes No
 Insured's Birth Date _____ SS/ID# _____ Group# _____
 Insured's Address _____ City _____ State _____ Zip _____
 Insured's Employer Name _____
 Insured's Employer Address _____ City _____ State _____ Zip _____
 Patient's Relationship to Insured: Self Spouse Child Other _____
 Insurance Plan Name _____ Phone (_____) _____
 Insurance Plan Address _____ City _____ State _____ Zip _____

SECONDARY DENTAL INSURANCE

Name of Insured _____ LAST NAME FIRST NAME INITIAL Is insured a patient? Yes No
 Insured's Birth Date _____ SS/ID# _____ Group# _____
 Insured's Address _____ City _____ State _____ Zip _____
 Insured's Employer Name _____
 Insured's Employer Address _____ City _____ State _____ Zip _____
 Patient's Relationship to Insured: Self Spouse Child Other _____
 Insurance Plan Name _____ Phone (_____) _____
 Insurance Plan Address _____ City _____ State _____ Zip _____

4. DENTAL HISTORY

Reason for today's visit _____ Chief dental complaint _____

Former Dentist _____ City/State _____ Last dental visit _____

INDICATE IF YOU HAVE, OR HAVE HAD, ANY OF THE FOLLOWING:

Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you drink mostly:	<input type="checkbox"/> Bottled/filtered water	<input type="checkbox"/> City water	<input type="checkbox"/> Well water
Pain when chewing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between the teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Questions on teeth whitening	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitive teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trauma to face or teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Tobacco chew	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tooth implant	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Orthodontic treatment- braces	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth or clenching	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Periodontal (gum) treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Use bitesplint / occlusal guard	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Wisdom teeth extraction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Complications with or following dental treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Jaw pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____			
Frequent Canker Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			

5. HEALTH HISTORY

Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No

If yes, what was the illness or problem: _____

Physician's name: _____ Date of last visit: _____

INDICATE IF YOU HAVE, OR HAVE HAD, ANY OF THE FOLLOWING:

Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pain on exertion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Implanted defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No
Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of Endocarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia or Blood Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease/Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen neck glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcer/Hyperacidity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bisphosphonate Medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oral _____ IV _____		Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	WOMEN – Pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Taking birth control pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental health problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Oral Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No		

DO YOU HAVE ANY DISEASE OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT? Yes No If yes, explain _____

6. MEDICATIONS

NONE

List All Medications You Are Currently Taking And The Reason For Taking. Please Include Non-Prescription:

7. ALLERGIES - PLACE CHECK IF "YES" TO THE FOLLOWING:

NONE

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Latex
<input type="checkbox"/> Barbiturates (sleeping pills)	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Codeine	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Iodine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Foods _____	<input type="checkbox"/> Other _____

Describe reaction _____

AUTHORIZATION AND ACKNOWLEDGMENT

1. I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
2. I authorize the dentist to release all information necessary to secure the payment of benefits.
3. I understand that I am financially responsible for all charges whether or not paid by insurance.
4. I certify that I have read and understand the above health history. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____