REGISTRATION HISTORY

Date_____/_____/_____

Patient's Name ______________________________ Date of Birth _____/_____/_____

(circle one) Single, Married, Widowed

Resident Phone # __________ Cell Phone # __________ Work # __________

Address ______________________ City __________ Zip Code __________

Social Security # ____________________

Person Responsible for this account ______________________________

Address (If Different) ______________________ City __________ Zip Code__________

Social Security # ____________________ Date of Birth _____/_____/_____

Relationship to Patient ____________________

PRIMARY INSURANCE INFORMATION

Employer ______________________________ Phone #__________

Address ______________________ City __________ Zip Code __________

Employee Name ______________________ Position __________ Hourly

Social Security or ID # ____________________ Date of Birth _____/_____/_____ Salaried

Insurance Co. ______________________________ Retired

Group # __________ Contract # (if any) ____________________

SECONDARY INSURANCE INFORMATION

Employer ______________________________ Phone #__________

Address ______________________ City __________ Zip Code __________

Employee Name ______________________ Position __________ Hourly

Social Security or ID # ____________________ Date of Birth _____/_____/_____ Salaried

Insurance Co. ______________________________ Retired

Group # __________ Contract # (if any) ____________________

I hereby authorize payment of insurance benefits directly to Canton Plymouth Family Dentistry.

Signature of covered person/employee ______________________________ Date __________

Whom may we thank for referring you? ______________________________

DO YOU TAKE ANTIBIOTICS BEFORE DENTAL TREATMENT? REASON:

MEDICATIONS

Please list any prescription medication you are currently taking: ______________________________

____

Please list any non-prescription (over-the-counter) medication you take regularly: ______________________________

____

MEDICAL HISTORY

Do you have or have you had any of the following? (Please check all that apply)

- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ High Blood Pressure
- ☐ Asthma or Lung Disease
- ☐ Hepatitis or Liver Disease
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ "AIDS" or HIV Positive
- ☐ Tuberculosis
- ☐ Steroid Therapy
- ☐ Seizures or Epilepsy
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Chemical Dependency
- ☐ Alcoholism
- ☐ Hearing Loss
- ☐ Psychiatric Care
- ☐ None of the Above

Have you been under the care of a physician in the last year? ☐ yes ☐ no

Reason: ______________________________

Name of Physician ______________________________

Address: ______________________________

____

____

ANESTHETICS

Have you ever had an unusual reaction to a local (dental) anesthetic? ☐ yes ☐ no

Have you ever had an unusual reaction to a general anesthetic? ☐ yes ☐ no

CERTIFICATION

The above information is accurate and complete to the best of my knowledge.

Date __________ Signature ______________________________

ALLERGIES

Please list any medications you are allergic to: (such as penicillin, aspirin, codeine) ______________________________

____

WOMEN ONLY

Are you pregnant? ☐ yes ☐ no

If yes, how many months? ______________________________

Are you nursing? ☐ yes ☐ no

DENTAL HISTORY

Do you presently have any of the following? (Please check all that apply)

- ☐ Loose Teeth
- ☐ Swelling
- ☐ Painful Teeth
- ☐ Chronic Headaches
- ☐ Feeling of Pressure in Mouth
- ☐ Difficulty Opening Mouth Wide
- ☐ None of the Above
- ☐ Bleeding Gums
- ☐ Bad Taste
- ☐ Sinus Problems
- ☐ Pain in Jaw Joints R___ L___
- ☐ Clicking or Popping in Jaw Joints R___ L___

BLEEDING

Have you ever had an episode of severe bleeding following surgery or removal of a tooth? ☐ yes ☐ no

Are you taking any blood-thinning medication? ☐ yes ☐ no

OTHER

Is there anything else you feel we should know about your medical or dental health?

____

____

____

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