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?

_____

_____

_____

_____