DENTAL REGISTRATION AND HISTORY

Patient Information

Patient Name _____ Preferred Name _____
Person Responsible for Account _____ Relation to Patient _____
Address _____
City _____ State _____ Zip_____
Home Phone _____Cell Phone _____ Email _____
Sex ☐M ☐F Birthdate _____ Social Security # _____
☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Whom may we thank for referring you? _____

Primary Insurance

Subscriber Name _____ Relation to Patient _____
Address _____
City _____ State _____ Zip_____
Birthdate _____ Social Security # _____
Subscriber Employed By _____Phone _____
Insurance Company _____Phone _____
Contract/Subscriber ID # _____ Group # _____

Additional Insurance

Is patient covered by additional Insurance? ☐Yes ☐No
Subscriber Name _____ Relation to Patient _____
Address _____
City _____ State _____ Zip_____
Birthdate _____ Social Security # _____
Subscriber Employed By _____Phone _____
Insurance Company _____Phone _____
Contract/Subscriber ID # _____ Group # _____

Dental History

Former Dentist _____ Phone _____
Address _____
City _____ State _____ Zip_____
Date of last dental care _____ Date of last dental x-rays _____
Have you had any problem associated with previous dental treatment? If yes, please explain _____
_____
How often do you brush your teeth? _____ How often do you floss your teeth? _____
What texture brush do you use? ☐SOFT ☐MEDIUM ☐HARD ☐NYLON ☐NATURAL
Do you prefer Nitrous Oxide during treatment? ☐Yes ☐No Do you prefer Headphones during treatment? ☐Yes ☐No

Please add anything you feel is important: _____

Check (√) if you have had problems with any of the following:

☐ Bad breath
☐ Bleeding gums
☐ Clicking or popping jaw, TMJ
☐ Food collection between teeth
☐ Grinding teeth
☐ Loose teeth/broken fillings
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Sensitivity when biting/chewing
☐ Sores or growths in your mouth

Medical History

Physician's Name _____ Phone _____

Date of last visit _____ General Health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Check (√) if you have had problems with any of the following:

☐ Anemia	☐ Circulatory Problems	☐ Hemophilia	☐ Respiratory Disease
☐ Arthritis/Rheumatism	☐ Cough, Persistent	☐ Hepatitis	☐ Rheumatic Fever
☐ Artificial Heart Valves	☐ Cough up Blood	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Joints	☐ Diabetes	☐ HIV/AIDS	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Jaw Pain	☐ Swelling Feet/Ankles
☐ Back Problems	☐ Fainting	☐ Kidney Disease	☐ Thyroid
☐ Blood Disease	☐ Glaucoma	☐ Liver Disease	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Pacemaker	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Radiation Treatment	☐ Ulcers

☐ Other _____

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

_____

_____

_____

Women: Are you pregnant? ☐ Yes ☐ No Due date _____

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

Check (√) if you are allergic to:

☐ Aspirin	☐ Latex	☐ Penicillin	☐ Other _____
☐ Codeine	☐ Local Anesthetic	☐ Sulfa	_____

Authorization

I certify that I, and/or my dependants have insurance coverage with _____
Name of Insurance Company(ies)

And assign directly to Dr. Robert Gano, D.D.S. 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 understand that a $10.00 finance charge may be assessed for any unpaid balance over 45 days. 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 payable for related services. This consent will end when my current treatment plan is completed.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to patient

In case of emergency contact _____ Phone _____

Date	Health Record Update