

# 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:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth              | <input type="checkbox"/> Sensitivity to hot              |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth/broken fillings | <input type="checkbox"/> Sensitivity to sweets           |
| <input type="checkbox"/> Clicking or popping jaw, TMJ  | <input type="checkbox"/> Periodontal treatment       | <input type="checkbox"/> Sensitivity when biting/chewing |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold         | <input type="checkbox"/> 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
- Arthritis/Rheumatism
- Artificial Heart Valves
- Artificial Joints
- Asthma
- Back Problems
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Other \_\_\_\_\_
- Circulatory Problems
- Cough, Persistent
- Cough up Blood
- Diabetes
- Epilepsy
- Fainting
- Glaucoma
- Headaches
- Heart Murmur
- Heart Problems
- Hemophilia
- Hepatitis
- High Blood Pressure
- HIV/AIDS
- Jaw Pain
- Kidney Disease
- Liver Disease
- Mitral Valve Prolapse
- Pacemaker
- Radiation Treatment
- Respiratory Disease
- Rheumatic Fever
- Shortness of Breath
- Stroke
- Swelling Feet/Ankles
- Thyroid
- Tobacco Habit
- Tonsillitis
- Tuberculosis
- Ulcers

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Women: Are you pregnant?  Yes  No  
Are you nursing?  Yes  No

Due date \_\_\_\_\_  
Taking birth control pills?  Yes  No

Check (✓) if you are allergic to:

- Aspirin
- Codeine
- Latex
- Local Anesthetic
- Penicillin
- Sulfa
- Other \_\_\_\_\_

**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