BETHESDA FAMILY SMILES

PATIENT REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date:_____ DOB:_____ Sex: ☐ M ☐ F

Patient Name:_____
Last Name

_____
First Name Middle Name

Address: _____

City:_____ State:____ Zip:_____

Home Phone:_____ Cell:_____

Email: _____

Preferred Contact Method: ☐ Home ☐ Cell ☐ Email

Select one:☐Minor ☐Single ☐ Married ☐Divorced

☐Widowed ☐Seperated

Employment/School Status: ☐Full Time ☐Part Time

Patient Employer/School: _____

Occupation:_____

Employer/School Address: _____

Employer/School Phone:_____

Spouse/Parent/Gurdian's Name:_____

Spouse/Parent/Gurdian's Phone:_____

Spouse/Parent/Gurdian's Employer:_____

Whom may we thank for referring you? _____

Person to contact in case of emergency:_____

_____ Phone:_____

2 DENTAL INSURANCE

PRIMARY INSURANCE

Policy Holder's Name:_____

_____

Relation to Patient: _____ DOB:_____ SS#_____

Address (if different):_____

City: _____ State:_____ Zip:_____

Phone:_____ Employer:_____

Insurance Company:_____

Subscriber ID #:_____

Group #:_____

ADDITIONAL INSURANCE

Does the patient have additional insurance? ☐ Yes ☐ No

Policy Holder's Name:_____

_____

Relation to Patient: _____ DOB:_____ SS#_____

Address (if different):_____

City: _____ State:_____ Zip:_____

Phone:_____ Employer:_____

Insurance Company:_____

Subscriber ID #:_____

Group #:_____

3 DENTAL HISTORY

Name of Previous Dentist and Location:_____ Date of Last Exam:_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2 Are your teeth sensitive to hot or cold liquids/food?	☐	☐
3.Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement?_____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

NEXT PAGE

PATIENT NAME: DOB:

4 MEDICAL HISTORY

Physician: Office Phone: Date of Last Exam:

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness in the last 5 years? If yes, please explain: _____ _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s)? _____ _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐
9. Are you wearing contact lenses?	☐	☐

	Yes	No
10. Are you allergic to or have you had any reactions to the following?	☐	☐
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
12. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Do you have or have you had any of the following?

☐ High Blood Pressure	☐ Kidney Disease	☐ Joint Replacement or Implant	☐ Glaucoma
☐ Heart Attack	☐ AIDS or HIV Infection	☐ Hepatitis/Jaundice	☐ Recent Weight Loss
☐ Rheumatic Fever	☐ Thyroid Problem	☐ Sexually Transmitted Disease	☐ Liver Disease
☐ Swollen Ankles	☐ Heart Diease	☐ Stomach Troubles/Ulcers	☐ Heart Trouble
☐ Fainting/Seizures	☐ Cardiac Pacemaker	☐ Chest Pains	☐ Respiratory Problems
☐ Asthma	☐ Heart Murmur	☐ Easily Winded	☐ Mitral Valve Prolapse
☐ Low Blood Pressure	☐ Angina	☐ Stroke	☐ Other: _____
☐ Epilepsy/Convulsions	☐ Emphysema	☐ Hay Fever/Allergies	_____
☐ Leukemia	☐ Cancer	☐ Tuberculosis	_____
☐ Diabetes	☐ Arthritis	☐ Radiation Therapy	

5 AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insrurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) **Date**

DOCTOR'S COMMENTS OFFICE USE ONLY