## DENTAL REGISTRATION AND HISTORY

Reason for today's visit Chew on one side of mouth Yes No Mouth prain, brushing Yes No Mouth prain, brushing Yes No Orthodontic treatment Yes No Prindental treatment Yes No No Sensitivity to cold Yes No Sensitivity to cold Yes No Sensitivity to sweets Yes	I II I LIVI TIVI ORD	IATION		EN	TAL INSURAN		
Assistant and the second of th	Data	Who	is respo	nsible f	or this account?		
Insurance Co.   Group #   Is patient covered by additional insurance?   Yes   No Subscriber's Name   Is patient Covered by additional insurance?   Yes   No Subscriber's Name   Is patient Covered by additional insurance?   Yes   No Subscriber's Name   Is patient Covered by additional insurance?   Yes   No Subscriber's Name   Is patient Covered by additional insurance?   Yes   No Subscriber's Name   Is patient Covered by additional insurance?   Yes   No Sensitivity to lead   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Isoachian Covered by additional insurance?   Yes   No Sare of Iso							
City   State   Zp     Is patient covered by additional insurance?   Yes   No   Subscriber's Name     Is patient covered by additional insurance?   Yes   No   Subscriber's Name     Is patient covered by additional insurance?   Yes   No   Subscriber's Name     Is patient covered by additional insurance?   Yes   No   Subscriber's Name     Is patient covered by additional insurance?   Yes   No   Subscriber's Name     Is patient covered by additional insurance?   Yes   No   Subscriber's Name     Is patient covered by additional insurance?   Yes   No   Sensitivity to name   Subscriber's Name     Is patient covered by additional insurance?   Yes   No   Sensitivity to name   Subscriber's Name     Is patient covered by additional insurance?   Yes   No   Sensitivity to name   Subscriber's Name     Is patient covered by additional insurance?   Yes   No   Sensitivity to name   Subscriber's Name     Is patient covered by additional insurance?   Yes   No   No   Is patient covered by additional insurance?   Yes   No   Subscriber's Name     Is patient covered by additional insurance?   Yes   No   No   Is patient covered by additional insurance?   Yes   No   No   Is patient covered by additional insurance?   Yes   No   No   Is patient covered by additional insurance?   Yes   No   Subscriber's Name     Is patient covered by additional insurance?   Yes   No   No   Is patient covered by additional insurance?   Yes   No   No   Is patient covered by additional insurance?   Yes   No   No   Is patient covered by additional insurance?   Yes   No   No   Is patient covered by additional insurance?   Yes   No   No   Is patient covered by additional insurance?   Yes   No   No   Is patient covered by additional insurance?   Yes   No   No   Is patient covered by additional insurance?   Yes   No   No   Insurance Co.   Subscriber's Name   Insurance Co.   Subscriber's Name   Insurance Co.   Subscriber's Name   Insurance Co.   Insura							
State   Zip   Birthdate   Simple   Married   Wildowed   Separated   Divorced   Subscriber's Name   Birthdate   SS#   Relationship to Patient   Insurance Co.   Group #   ASSIGNMENT AND RELEASE   The underspread certify that I for my dependently have insurance benefits   The underspread certify that I for my dependently have insurance benefits   The underspread certify that I for my dependently have insurance benefits   The underspread certify that I for my dependently have insurance benefits   The underspread certify that I for my dependently have insurance benefits   The underspread certify that I for my dependently have insurance benefits   The underspread certify that I for my dependently have insurance benefits   The underspread certify that I for my dependently have insurance benefits   The underspread certify that I for my dependently have insurance benefits   The underspread certify that I for my dependently have insurance certification   The underspread certify that I for my dependently have insurance certification   The underspread certify that I for my dependently have insurance certification   The underspread certify that I for my dependently have insurance certification   The underspread certify that I for my dependently have insurance certification   The underspread certifica	SS	Insui	ance Co				
Is patient covered by additional insurance?   Yes   No	City State	Grou	p #				
Subscriber's Name Birthdate SS# Inccupation Insurance Co.		le na	tient cov	ered by	additional insurance? 🗖 Yes	□ No	
Birthdate SS#   Relationship to Patient   Insurance Co.   Group #   ASIGMENT AND RELEASE   In the undersigned certify that I (or my dependent) have insurance.   Group #   ASIGMENT AND RELEASE   In the undersigned certify that I (or my dependent) have insurance.   And assign direction of the signature of the sig		Cubo	criber's	Name			
Relationship to Patient Insurance Co. Group # ASSIGNMENT AND RELEASE I. the undersigned certify that 1 (or my dependent) have insurance co. with Work interpret the use of this signature or all insurance submissions.  Whom may we thank for referring you?  PHONE NUMBERS  Work Cell Best time to reach you  N CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)  AREA TO THE		Divolced					
Insurance Co.  Group #  ASSIGNMENT AND RELEASE  I, the underragend certify that I (or my dependent) have insurance or with meaning that the insurance content of the supervisor property of the supervisor property of the supervisor on one paid by insurance. I theretory a the doctor to release all information on one insurance submissions.  Whom may we thank for referring you?  Whom may we thank for referring you?  PHONE NUMBERS  The supervisor of the supervisor on one paid by insurance. I theretory a the doctor to release all information on one property disparative on all insurance submissions.  Responsible Party Signature  Relationship  Date  PHONE NUMBERS  The supervisor of the supervisor on the party by insurance submissions.  Responsible Party Signature  Relationship  Dental HISTORY  Burning sensation on tongue   Yes   No   Loose teeth or broken fillings   Yes   Yes   No   Cigarette, pipe, or   Cigar smoking   Yes   No   Cigarette, pipe, or   Cigar smoking   Yes   No   Cigarette, pipe, or   Yes   No   Mouth pain, brushing   Yes   Yes   No   Cigarette, pipe, or   Yes   No   Cigarette, pipe, or   Yes   No   Cigarette, pipe, or   Yes   No   Sensitivity to cold   Yes   No   Sensitivity to cold   Yes   No   Sensitivity to load   Yes   Yes   No   Sensitivity to the paid of t	nt SS#						
mployer Address mployer Phone  Group #  ASSIGNMENT AND RELEASE In the undersigned certify that I (or my dependent) have insurance contents and assign of with the undersigned certify that I (or my dependent) have insurance contents and assign of the undersigned certify that I (or my dependent) have insurance contents and assign of the undersigned certify that I (or my dependent) have insurance contents and assign of the undersigned certify that I (or my dependent) have insurance contents and assign of the undersigned certify that I (or my dependent) have insurance contents and assign of the undersigned certify that I (or my dependent) have insurance contents and assign of the undersigned certify that I (or my dependent) have insurance contents and assign of the undersigned certify that I (or my dependent) have insurance contents and assign of the undersigned certify that I (or my dependent) have insurance contents and assign of the undersigned certify that I (or my dependent) have insurance contents and assign of the undersigned certify that I (or my dependent) have insurance contents and assign of the decir to release all information necessary to secure the payment of I authorize the decir or release all information necessary to secure the payment of I authorize the decir or release all information necessary to secure the payment of I authorize the decir or release all information necessary to secure the payment of I authorize the decir or release all information necessary to secure the payment of I authorize the decir or release all information necessary to secure the payment of I authorize the decir or release all information necessary to secure the payment of I authorize the decir or release all information necessary to secure the payment of I authorize the decir or release all information necessary to secure the payment of I authorize the decir or release all information necessary to secure the payment of I authorize the decir or release all information necessary to secure the payment of I authorize the dec	pation						
ASSIGNMENT AND RELEASE Is the undersigned certify that I (or my dependent) have insurance or and assign of with the undersigned certify that I (or my dependent) have insurance or and assign of with the undersigned certify that I (or my dependent) have insurance or and assign of with the undersigned certify that I (or my dependent) have insurance or and assign of with the undersigned certify that I (or my dependent) have insurance or and assign of with the undersigned certify that I (or my dependent) have insurance or all insurance benefits of the order to release all information necessary to secure the payment of I authorize the use of this signature on all insurance submissions.  PHONE NUMBERS  The undersigned certify that I (or my dependent) have insurance or all insurance or	oyer	Insu	rance Co	٠			
ASSIGNMENT AND RELEASE  In the undersigned certify that I (or my dependent) have insurance or with	over Address	Grou	ıp #				
with		ASS				urance co	oraga
A continue		1 1, 110			and a	assign dire	ctly to
responsible for all charges whether or not paid by insurance. I hereby a the doctor to release all information necessary to secure the payment of I authorize the use of this signature on all insurance submissions.  Responsible Party Signature  Relationship  Date  PHONE NUMBERS    Relationship		Dr			all insurance	benefits,	if any,
Authorize the use of this signature on all insurance submissions.   Responsible Party Signature   Relationship   Date		respo	nsible for	all charge	s whether or not paid by insurance. I	hereby au	thorize
PHONE NUMBERS    Mork		the do	octor to rel	ease all in use of this	nformation necessary to secure the pa signature on all insurance submission:	yment of b s.	enefits
PHONE NUMBERS    Cell	Factorial Factorial State of the Control of the Con						
PHONE NUMBERS    Dent	n may we thank for referring you?	Res	ponsible Pa	arty Signat	ure		
PHONE NUMBERS    Sest time to reach you					Doto		
Best time to reach you		Reia	itionship		Date		
N CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)    Name							
Relationship	1	Best tin	ne to rea	ch you <sub>-</sub>			
Burning sensation on tongue	ASE OF EMERGENCY, CONTACT (S	pecify someone who does not	live in y	our hou	isehold.)		
DENTAL HISTORY    Burning sensation on tongue   Yes   No   Loose teeth or broken filings   Yes   Yes   No   Mouth breathing   Yes   Yes   No   Mouth pain, brushing   Yes   Yes   No   Pain around ear   Yes   Yes   No   Periodontal treatment   Yes   Yes   No   Periodontal treatment   Yes   Yes   No   Sensitivity to cold   Yes   Yes   No   Sensitivity to heat   Yes   Yes   No   Sensitivity to sweets   Yes   Yes   No   Sensitivity to sweets   Yes   Yes   No   Sensitivity when biting   Yes   No   No   No   No   No   No   No   N		Relatio	nship				
Burning sensation on tongue							
Burning sensation on tongue		Work/C	all Phon	ρ			
Burning sensation on tongue		Work/C	ell Phon	е			
Burning sensation on tongue		Work/C	ell Phon	e			
Reason for today's visit Chew on one side of mouth Yes No Mouth prain, brushing Yes Yes No Mouth pain, brushing Yes Yes No Orthodontic treatment Yes Yes No Pain around ear Yes Yes No Periodontal treatment Yes Yes No Sensitivity to cold Yes No Sensitivity to cold Yes No Sensitivity to sweets Yes No Yes No Yes No Yes No Sensitivity when biting Yes No Yes No Yes No Sensitivity when biting Yes No Yes No	e Phone		ell Phon	e			
Cigarette, pipe, or cigar smoking  City/State	DENTAL HISTOR	Y					
City/State Dry mouth	DENTAL HISTOR	<b>Y</b> Burning sensation on tongue	□ Yes	□ No	Loose teeth or broken filings	⊐ Yes	□ No
Clicking or popping jaw	DENTAL HISTOR son for today's visit	Y Burning sensation on tongue Chew on one side of mouth	□ Yes	□ No □ No	Loose teeth or broken filings Mouth breathing	□ Yes	□ Ne
Dry mouth	DENTAL HISTOR  son for today's visit	Y  Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or	□ Yes	□ No □ No	Loose teeth or broken filings Mouth breathing Mouth pain, brushing	⊐ Yes	□ N( □ N(
Date of last dental X-rays Food collection between the teeth Sensitivity to heat Sensitivity to sweets Yes or "No" where indicated for all that apply: Foreign objects Yes No Sensitivity when biting Yes Would you like whiter teeth? Yes No Grinding teeth Yes No Sores or growths in mouth Yes Bad breath Yes No Sores or growths in mouth Yes No Bleeding gums Yes No Jaw Pain or tiredness Yes No How often to you floss?	DENTAL HISTOR  son for today's visit	Y  Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking	☐ Yes☐ Yes☐ Yes☐ Yes	□ No □ No □ No	Loose teeth or broken filings Mouth breathing Mouth pain, brushing Orthodontic treatment	☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes	Ne
Check "Yes" or "No" where indicated for all the teeth Sensitivity to sweets Yes No Sensitivity when biting Yes Would you like whiter teeth? Yes No Gums swollen or tender Bleeding gums Yes No Jaw Pain or tiredness Sensitivity to sweets Yes No Sensitivity when biting Yes No Sores or growths in mouth Yes No How often to you floss?	DENTAL HISTOR  son for today's visit  ner Dentist State	Y  Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth	☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes	□ No □ No □ No	Loose teeth or broken filings Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment	☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes	No
Foreign objects  Would you like whiter teeth?	DENTAL HISTOR  Son for today's visit  ner Dentist State of last dental visit	Y  Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth	☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes	No   No   No   No   No   No   No   No	Loose teeth or broken filings Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold	Yes	- N
Would you like whiter teeth?	DENTAL HISTOR  Son for today's visit  ner Dentist State of last dental visit	Y  Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth Fingernail biting Food collection between	☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes	No   No   No   No   No   No   No   No	Loose teeth or broken filings Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat	☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes	
Bad breath	DENTAL HISTOR  Son for today's visit  ner Dentist  State  of last dental visit  of last dental X-rays  ck "Yes" or "No" where indicated for all	Y  Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth Fingernail biting Food collection between the teeth	Yes Yes Yes Yes Yes Yes Yes Yes	No   No   No   No   No   No   No   No	Loose teeth or broken filings Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat Sensitivity to sweets	Yes	No
Bleeding gums	DENTAL HISTOR  Son for today's visit  ner Dentist State of last dental visit of last dental X-rays ck "Yes" or "No" where indicated for all apply:	Y  Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth Fingernail biting Food collection between the teeth Foreign objects	Yes Yes Yes Yes Yes Yes Yes Yes Yes	No   No   No   No   No   No   No   No	Loose teeth or broken filings Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat Sensitivity to sweets Sensitivity when biting	Yes	No
Dieeuling guins	DENTAL HISTOR  Son for today's visit	Y  Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth Fingernail biting Food collection between the teeth Foreign objects Grinding teeth	Yes	No   No   No   No   No   No   No   No	Loose teeth or broken filings Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat Sensitivity to sweets Sensitivity when biting	Yes	No   No   No   No   No   No   No   No
Blisters on lips or mouth	DENTAL HISTOR  Son for today's visit	Y  Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth Fingernail biting Food collection between the teeth Foreign objects Grinding teeth Gums swollen or tender	Yes	No   No   No   No   No   No   No   No	Loose teeth or broken filings Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat Sensitivity to sweets Sensitivity when biting Sores or growths in mouth	Yes	

	HIST	<u> </u>							
hysician's Name							Date of last visit		
lace a mark on "Yes" or "No									
					☐ Yes	□ No	Psychiatric Care	☐ Yes	D No
IDS	☐ Yes ☐				☐ Yes		Radiation Treatment	☐ Yes	
Izheimers	☐ Yes ☐		Epilepsy Fainting or dizziness		☐ Yes		Respiratory Disease	Yes	
nemia	☐ Yes ☐		Glaucoma		☐ Yes		Rheumatic Fever	Yes	
rthritis, Rheumatism			Headaches		Yes		Scarlet Fever	☐ Yes	
rtificial Heart Valves	☐ Yes ☐		Heart Murmur		☐ Yes		Shortness of Breath	☐ Yes	
rtificial Joints	□ Yes □				☐ Yes			☐ Yes	
sthma	□ Yes □		Heart Problems				Sinus Trouble	☐ Yes	
ack Problems	☐ Yes ☐	33	Hepatitis (Type		☐ Yes		Skin Rash		
leeding abnormally, with	☐ Yes ☐	No	Herpes		☐ Yes		Special Diet	☐ Yes	
extraction or surgery	□ \/aa □	. Na	High Blood Pressure		☐ Yes		Stroke	☐ Yes	
lood Disease	☐ Yes ☐		HIV Positive		☐ Yes		Swelling of Feet or Ankles	☐ Yes	
ancer	☐ Yes ☐		Jaundice		☐ Yes		Swollen Neck Glands	☐ Yes	
hemical Dependency	☐ Yes ☐		Jaw Pain		☐ Yes		Thyroid Problems	☐ Yes	
hemotherapy	□ Yes □		Kidney Disease		☐ Yes		Tonsillitis	☐ Yes	
Circulatory Problems	☐ Yes ☐		Liver Disease		☐ Yes		Tuberculosis	🗅 Yes	
Congenital Heart Lesions	☐ Yes ☐		Low Blood Pressure		☐ Yes		Tumor or growth on	Yes	
Cortisone Treatments	Yes		Mitral Valve Prolapse		☐ Yes		head or neck	- W	- N
Cough, persistent or bloody			Nervous Problems		☐ Yes		Ulcer	☐ Yes	
iabetes	☐ Yes ☐	ı No	Pacemaker		☐ Yes	□ No	Venereal Disease	☐ Yes	ш I
VOMEN: Are you: Pregn	ant? 🗀 Yes	5,	Months 🖵 No	Nursing	? ⊐ Ye	s 🖵 No	Taking birth control pills	? 🗆 Yes	
MEDI	CATI	ON	IS				ALLERGIES		
ist medications you are curr	rontly taking			□ As	oirin		☐ Penicillin		
ist inedications you are curi	Gitty taking	•				(0)			
				<b>□</b> ва	rbiturate	s (Sieet	oing pills) 🔲 Sulfa		
				☐ Co	deine		□ Other		
					line				
Pharmacy Name	And the production of the prod			□ La	tex			**************************************	
Phone				□ Lo	cal Anes	thetic			
					498	Tyskihel Tee			
			X						
<b>2</b>			SIGNATU	JRE OF	PATIEN	T OR P	ARENT OF MINOR		
UPDATE	S (To be	filled	in at future appointme	ents)					
	n vour healt	h sin	ce vour last dental appo	intment	? 🗆 Ye	s 🗀 No	)		
Has there been any change in									
or what conditions?									
For what conditions? Are you taking any new med	ications?		If so, w	hat					
For what conditions? Are you taking any new med	ications?		If so, w	hat			Date		
For what conditions? Are you taking any new med Patient's Signature	ications?		If so, w	hat			Date		
For what conditions? Are you taking any new med Patient's Signature Doctor's Signature	ications?		If so, w	hat			Date Date		
For what conditions? Are you taking any new med Patient's Signature Doctor's Signature	ications?		If so, w	hat			Date Date		
Doctor's Signature Has there been any change i	ications? n your healt	h sin	If so, w	hat	? □ Y€	s 🗆 N	Date Date 0		
For what conditions?Are you taking any new med Patient's Signature Doctor's Signature Has there been any change i	ications? n your healt	h sin	If so, w	hat	? 🗅 Ye	s 🗆 N	Date Date o		• • •
For what conditions?Are you taking any new med Patient's SignatureDoctor's SignatureHas there been any change in For what conditions?	ications? n your healt	h sin	If so, w	hat	? 🗅 Ye	s 🗆 N	Date Date o		• • •
For what conditions? Are you taking any new med Patient's Signature Doctor's Signature Has there been any change i For what conditions? Are you taking any new med	ications? n your healt	h sin	ce your last dental appo	hat	? □ Y€	s 🗅 N	Date Date 0		

## TWIN DENTAL 640 N. RIVER RD SUITE 100 NAPERVILLE, IL 60563 630-355-3355

Acknowledgment of Receipt of Notice of Privacy Practices (You may refuse to sign this acknowledgment, initial next to refusal line and sign.)

I acknowledge that I have received the Twin Dental Notice of Privacy Practices.

Patient Name (Print)	Date
Patient Signature	Patient Date of Birth
Power of Attorney/Legal Repres	sentative (Print)
If person signing is Power of At	torney/Legal Representative, describe relationship to patient:
Messages Twin Dental has my permission	to leave information regarding my dental health care:
Home Answering	Machine (
Cell Phone:	
Release of Information Twin Dental has my permission individuals:	to communicate my health information with the following
Name:	Relationship to Patient:
Phone: (	
Name:	Relationship to Patient:
Phone:( ) -	

Refusal of Acknowledgment We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but acknowledgment could not be obtained due to: (Please initial and sign)
Individual refused to sign
Communication barriers prohibited obtaining acknowledgment
An emergency situation prevented us from obtaining acknowledgment
Other:
Patient Signature or Power of Attorney/Legal Representative Date