

DENTAL REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Whom may we thank for referring you? _____

2

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____

Date _____

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PHONE NUMBERS

Home _____ Work _____ Cell _____

E-Mail _____ Best time to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work/Cell Phone _____

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DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Check "Yes" or "No" where indicated for all that apply:

Would you like whiter teeth? ☐ Yes ☐ No

Bad breath ☐ Yes ☐ No

Bleeding gums ☐ Yes ☐ No

Blisters on lips or mouth ☐ Yes ☐ No

Burning sensation on tongue ☐ Yes ☐ No

Chew on one side of mouth ☐ Yes ☐ No

Cigarette, pipe, or cigar smoking ☐ Yes ☐ No

Clicking or popping jaw ☐ Yes ☐ No

Dry mouth ☐ Yes ☐ No

Fingernail biting ☐ Yes ☐ No

Food collection between the teeth ☐ Yes ☐ No

Foreign objects ☐ Yes ☐ No

Grinding teeth ☐ Yes ☐ No

Gums swollen or tender ☐ Yes ☐ No

Jaw Pain or tiredness ☐ Yes ☐ No

Lip or cheek biting ☐ Yes ☐ No

Loose teeth or broken fillings ☐ Yes ☐ No

Mouth breathing ☐ Yes ☐ No

Mouth pain, brushing ☐ Yes ☐ No

Orthodontic treatment ☐ Yes ☐ No

Pain around ear ☐ Yes ☐ No

Periodontal treatment ☐ Yes ☐ No

Sensitivity to cold ☐ Yes ☐ No

Sensitivity to heat ☐ Yes ☐ No

Sensitivity to sweets ☐ Yes ☐ No

Sensitivity when biting ☐ Yes ☐ No

Sores or growths in mouth ☐ Yes ☐ No

How often do you floss? _____

How often do you brush? _____

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HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (Type _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extraction or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No		

WOMEN: Are you: **Pregnant?** ☐ Yes, _____ Months ☐ No **Nursing?** ☐ Yes ☐ No **Taking birth control pills?** ☐ Yes ☐ No

MEDICATIONS

List medications you are currently taking:

Pharmacy Name _____

Phone _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Codeine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Iodine	_____
<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Local Anesthetic	_____

X

SIGNATURE OF PATIENT OR PARENT OF MINOR

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UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

**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 Representative (Print)

If person signing is Power of Attorney/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 to communicate my health information with the following individuals:

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