DENTAL REGISTRATION AND HISTORY

(please print)

Date_____ Home Phone (_____) _____

Patient _____
Last Name First Name Middle Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

E-mail _____ Cell Phone (_____)_____ Sex M F

Age _____ Birth date _____ Married Divorced Widowed

Employer/School _____ Occupation _____ Employer Phone (_____) _____

Spouse/Parent Name _____ Spouse/Parent Birth date _____

Spouse/Parent Employed by _____ Occupation _____ Employer Phone (_____) _____

Who is responsible for this account?_____ Relationship to Patient _____

Social Security # _____ Spouse/Parent Social Security # _____

Dental Insurance Yes No Group Carrier and phone number_____ Group #_____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of last Physical _____

Have you ever had any of the following? (check boxes that apply):

Allergies	Epilepsy	Pacemaker	
Arthritis	Headaches	Psychiatric Care	
Artificial Heart Valves or Joints, Screws, etc	Heart Murmur	Radiation Treatment	
Back Problems	Heart Problems	Recent Weight Loss	
Bleeding abnormally with extractions	Hemophilia	Respiratory Disease	
Blood Disease	Hepatitis, Jaundice or liver disease	Sinus Problems	
Cancer	High Blood Pressure	Stroke	
Chemical dependency	HIV/AIDS	Thyroid Problems	
Circulatory Problems	Kidney Disease	Ulcer	
Congenital Heart Lesions	Low Blood Pressure		
Diabetes	Mitral Valve Prolapse		

ALLERGIES

Aspirin Codeine Latex Local Anesthetic Penicillin Other _____

Have you ever responded adversely to medical or dental treatment? Yes No Are you taking any medication at this time? Yes No

If so, what? _____

Are you under the care of a physician? Yes No For what conditions? _____

(Women) Do you suspect that you are pregnant? Yes No Due date _____ Are you nursing? Yes No

Is there anything else we should know about your medical history?_____

_____

DENTAL HISTORY

Reason for today's visit_____

Former Dentist _____ Date of last dental visit _____ Date of last dental x-rays _____

Have you ever had any of the following? (check boxes that apply):

Bad Breath	Cigarette, pipe or cigar smoking	Gums swollen or tender	Periodontal Treatment
Bleeding Gums	Clicking or popping jaw	Jaw pain or tiredness	Sensitivity to cold
Blisters on lips or mouth	Dry Mouth	Lip or cheek biting	Sensitivity to heat
Burning sensation on tongue	Food collection between teeth	Loose teeth or broken fillings	Sensitivity to sweets
Chew on one side of mouth	Grinding Teeth	Orthodontic treatment	How often do you brush/floss? _____

What would you like to see different about your smile?_____

CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent(s) is covered by insurance with _____and assign directly to **Dr. James R. Pitts II DMD**
Name of Insurance Company(ies)

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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's 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 or the benefit payable for related services.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. The patient's **DEDUCTIBLE** and **ESTIMATED PORTION** are due at the time of treatment. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Method of Payment Cash Check Credit Card

_____ _____
Signature of Parent, Guardian or Patient (if over 18) Date

_____ _____
Please print name of Parent, Guardian or Patient (if over 18) Date

There is a $35 fee for all returned checks

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? Yes No For what conditions?_____

Is the patient taking any new medications? Yes No If so, what? _____

_____ _____
Patient/Guardian Signature Date

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? Yes No For what conditions?_____

Is the patient taking any new medications? Yes No If so, what? _____

_____ _____
Patient/Guardian Signature Date

MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment? Yes No For what conditions?_____

Is the patient taking any new medications? Yes No If so, what? _____

_____ _____
Patient/Guardian Signature Date