DENTAL REGISTRATION AND HISTORY

Name (last)_____ (first)_____ (mi)_____ Date of birth._____

Home Address_____ Apt._____ Home phone ( )_____

City_____ State_____ Zip_____ Bus phone ( )_____

Social Security Number_____ Male_____ Female_____ Employer Address_____

Occupation_____ Employer_____ Phone # _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Referred by _____

In case of emergency (name)_____ Relationship_____ Phone ( )_____

Dental Insurance:

Insurance Co._____ Subscriber Name _____

Relationship to patient _____ Policy No._____ Group No. _____

Is patient covered by additional insurance? ☐ Yes ☐ No

If yes, Subscriber's Name_____ Relationship to patient _____

DENTAL HISTORY

Reason for today's visit_____

Date of last dental visit _____

Date of last dental X-rays _____

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

Bad breath	☐ Yes	☐ No	Clicking or popping jaw	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Dry mouth	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Fingernail biting	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Food collection between the teeth	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Foreign objects	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Lip or cheek biting	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Loose teeth or broken fillings	☐ Yes	☐ No			
			Mouth breathing	☐ Yes	☐ No	How often do you floss?_____		
			Mouth pain, brushing	☐ Yes	☐ No	How often do you brush?_____		

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	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
			Heart Problems	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
			Hepatitis Type_____	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Swelling of feet or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tonsilitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
			Mitral Valve Prolapse	☐ Yes	☐ No			

Allergies: Penicillin ☐ Yes ☐ No Local Anesthetic ☐ Yes ☐ No Codeine ☐ Yes ☐ No Latex ☐ Yes ☐ No Other _____

Medications: List medications you are currently taking _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Authorization

I authorize my insurance company to pay to the dentist group all insurance benefits otherwise payable to me for service rendered.
I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.
I understand a charge may incur if 48 hours notice is not given on a cancellation.
I also understand that I will be responsible for billed charges, interest costs of 24 per annum or 2.0% periodic rate per month, starting from the date of procedure, and all legal and collection costs, if bill is not paid in full.

Signature_____ Date_____

Payment is due in full at time of treatment unless prior arrangements have been approved.

DENTAL ASSOCIATES OF NEW YORK

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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