

# HERITAGE FAMILY DENTAL - REGISTRATION AND HISTORY

## PATIENT INFORMATION

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone – Home: \_\_\_\_\_

Cell: \_\_\_\_\_

Work: \_\_\_\_\_ Ext: \_\_\_\_\_

Can you be reached at work?  Yes  No

Email: \_\_\_\_\_

Sex:  M  F Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced

Patient Employer/School: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Spouse's/Partner's Name: \_\_\_\_\_

Phone – Cell: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## EMERGENCY NUMBER

*(Specify someone who does not live in household)*

Name: \_\_\_\_\_

Phone – Home: \_\_\_\_\_

Work/Cell: \_\_\_\_\_

Relationship: \_\_\_\_\_

## DENTAL HISTORY

<p>Reason for today's visit: _____</p> <p>Former Dentist: _____</p> <p>City/State: _____</p> <p>Phone #: _____</p> <p>Date of last dental visit: _____</p> <p>Date of last dental X-rays: _____</p> <p><i>Place a mark on "yes" or "no" to indicate if you have had any of the following:</i></p> <p>Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Food collection between teeth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Foreign object <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Use of any tobacco products <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How often do you floss? _____</p> <p>How often do you brush? _____</p> <p>Do you currently have a bitesplint? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you active in sports? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you wear a mouth guard? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you snore? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does it disturb your partner? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you had a sleep study done? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, who: _____</p>
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## DENTAL INSURANCE

Subscriber's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Group #: \_\_\_\_\_

Does patient have additional insurance?  Yes  No

Subscriber's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Group #: \_\_\_\_\_

## ASSIGNMENT AND RELEASE

**PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT**  
*Unless prior arrangements have been made*

I understand that I am responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment directly to Heritage Family Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of my information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I have received a copy of this office Notice of Privacy Practices.

Signature of Patient/Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

