

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____
 Name _____
 Address _____
 City _____
 State _____ Zip _____
 Sex: Male Female Age _____
 Date of Birth _____
 Married Divorced Single
 Widowed Separated
 SS # _____
 Patient Employer/School _____
 Occupation _____
 Employer/School Phone (_____) _____
 Spouse/Parent Name _____
 Employer _____
 Occupation _____
 Employer Phone (_____) _____
 SS # _____
 How did you hear about us?
 Sign
 Phone Book _____
 Newspaper _____
 Family/Friend Referral _____
 Other _____
We thank you for accepting their referral and our invitation.

DENTAL INSURANCE

Who is responsible for this account? _____
 Relationship to patient? _____
 Insurance Company? _____
 Group # _____
 Is patient covered by additional insurance? Yes No
 Subscriber's Name _____
 Date of Birth _____ SS # _____
 Relationship to patient? _____
 Insurance Company? _____
 Group # _____
Assignment and Release
 I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign _____
 Name of insurance Company(ies)
Advanced Dental Concepts/Dr. Danny L. Hayes all insurance benefits, if any, payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance submissions.
 The above named dentist may use my health care information and may disclose information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services rendered and determining insurance benefits or the benefits payable for related services. This consent will end when current treatment is completed or one year from the date signed below.

 Signature of patient, parent/guardian, or personal representative

 Please print name of patient, parent/guardian, or personal representative

 Date _____ Relationship to patient _____

PHONE NUMBERS

Home (_____) _____ - _____ Work (_____) _____ - _____ Ext. _____ Cell (_____) _____
 Spouse's Work (_____) _____ - _____ Best time and place to reach you? _____

IN CASE OF EMERGENCY, CONTACT (specify anyone who does not live in your household)

Name _____ Relationship _____
 Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

DENTAL HISTORY

Reason for today's visit? _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit? _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
What was done? _____	Cigarette, cigar, pipe smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Were X-Rays taken? _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any of the following:	Dry Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to hot <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Chew on Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____

Advanced Dental Concepts • 10771 Randolph Street • Crown Point, IN 46307 • (219) 663-9679 • Dr. Danny L. Hayes

E-Mail Address _____

MEDICAL HISTORY

Patient Name _____ Date of Birth _____

Are you under the care of a physician now?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
Have you ever been hospitalized for a major operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
Have you ever had a serious head or neck injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
Are you taking any medications, pills or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
Are you on a special diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
Do you use recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	_____
Women: are you <input type="checkbox"/> Pregnant/Trying to get pregnant	<input type="checkbox"/> Nursing?	<input type="checkbox"/> Taking Birth Control Medications?

Are you **ALLERGIC** to any of the following:

- Aspirin
 Penicillin
 Codeine
 Acrylic
 Metal
 Latex
 Local Anesthetics
 Other _____

Do you have or have you had any of the following?

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease/Trait |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur * | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intest. Disease |
| <input type="checkbox"/> Artificial Heart Valve * | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker * | <input type="checkbox"/> Mitral Valve Prolapse * | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint * | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever * | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

* Condition may require antibiotic premedication

N/A - Not Answered by Patient

Have you had any serious illness not listed above? Yes No N/A _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____