



## REGISTRATION AND MEDICAL HISTORY

Today's Date \_\_\_\_\_ Home Phone (    )    -

Cell Phone (    )    -

### PATIENT INFORMATION

Name \_\_\_\_\_ SOCIAL SECURITY No. \_\_\_\_\_  

Last Name
First Name
Middle Initial

Street Address \_\_\_\_\_ E-mail \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Single     Married     Partnered     Minor  
 Widowed     Separated     Divorced

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Employer/School Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other family members seen here: \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone (    )    -

### INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person Responsible for Account \_\_\_\_\_  

Last Name
First Name
Middle Initial

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ ID#/SS# \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone (    )    -

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone (    )    -

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Names of the other dependents covered under this plan \_\_\_\_\_

### AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)  
**WALL STREET DENTAL** 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 dentist may use my 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 benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print of patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Relationship to Patient

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

***Please Complete Above Information and Next Page***

## DENTAL HISTORY

Reason for Today's Visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental X-ray \_\_\_\_\_

Check (  ) if you have had problems with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## MEDICAL HISTORY

Physician Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? these include combination of Ionimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfloramine) and Redux (dexfenfluramin).  Yes  No

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pill?  Yes  No

Check (  ) if you have or have had any the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis Rheumatism    | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problem            | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problem        | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |

### MEDICATION

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"/> Latex _____ |
| <input type="checkbox"/> Local Anesthetic              | <input type="checkbox"/> Other _____ |

## SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever have a change in health.

\_\_\_\_\_  
Signature of patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print of patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Relationship to Patient