



## DENTAL REGISTRATION AND HISTORY

<b>1. PATIENT INFORMATION</b>	<b>2. DENTAL INSURANCE</b>
DATE _____ PATIENT NAME _____ <div style="text-align: right; margin-left: 100px;">LAST</div> FIRST _____ MIDDLE INITIAL _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ EMAIL _____ <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE DATE OF BIRTH _____ SOCIAL SECURITY # _____ <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> OTHER EMPLOYER _____ EMPLOYER ADDRESS _____ EMPLOYER PHONE _____ SPOUSE NAME _____ BIRTHDATE _____ SS # _____ SPOUSE'S EMPLOYER _____ WHO MAY WE THANK FOR REFERRING YOU? _____	WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ RELATIONSHIP TO PATIENT _____ INSURANCE COMPANY _____ GROUP # _____ POLICY # _____ IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO SUBSCRIBER'S NAME _____ BIRTHDATE _____ SS# _____ RELATIONSHIP TO PATIENT _____ EMPLOYER _____ INSURANCE COMPANY _____ GROUP # _____ POLICY # _____ ASSIGNMENT AND RELEASE: I CERTIFY THAT I, AND/OR MY DEPENDENTS, HAVE INSURANCE COVERAGE WITH _____ AS I ASSIGN DIRECTLY TO – CARL A. SMUDDE, DDS, 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 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 ALLOW CARL A. SMUDDE, DDS TO USE MY HEALTH CARE INFORMATION FOR THE TREATMENT AND DAY TO DAY HEALTHCARE OPERATIONS OF MY TREATMENT. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETE OR ONE YEAR FROM THE DATE SIGNED BELOW. I ALSO UNDERSTAND THAT I MAY REVIEW AND SECURE A COPY OF YOUR NOTICE OF PRIVACY PRACTICES, WHICH CONTAINS A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION. AND MY RIGHTS UNDER HIPAA. _____ SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ PLEASE PRINT NAME OF PATIENT, PARENT OR GUARDIAN _____ DATE _____ RELATIONSHIP TO PATIENT _____ HAVE YOU BEEN TREATED BY ANOTHER DENTIST WITHIN LAST 12 NAME OF DENTIST _____
<h3 style="margin-top: 20px;">3. PHONE NUMBERS</h3> HOME ( ) _____ WORK ( ) _____ CELL ( ) _____ SPOUSE'S WORK ( ) _____ EMERGENCY ( ) _____ SOMEONE WHO DOES NOT LIVE IN YOUR HOUSEHOLD RELATIONSHIP _____ BEST TIME TO CALL _____ MAY WE CALL YOU AT WORK? _____	

# PATIENT HEALTH HISTORY

PHYSICIAN'S NAME \_\_\_\_\_ DATE OF LAST PHYSICAL EXAM \_\_\_\_\_

ARE YOU CURRENTLY UNDER MEDICAL CARE? \_\_\_\_\_ WHAT FOR? \_\_\_\_\_

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

- |                                               |                                                   |                                                       |
|-----------------------------------------------|---------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> ANY HEART PROBLEMS   | <input type="checkbox"/> ALLERGIC TO ANESTHETICS  | <input type="checkbox"/> TYPHOID FEVER                |
| <input type="checkbox"/> RHEUMATIC FEVER      | <input type="checkbox"/> ALLERGIES TO MEDICINES   |                                                       |
| <input type="checkbox"/> HEART MURMUR         | <input type="checkbox"/> ALLERGIES TO LATEX       | <input type="checkbox"/> TONSILLITIS                  |
| <input type="checkbox"/> STROKE               | <input type="checkbox"/> OTHER ALLERGIES _____    | <input type="checkbox"/> CIRCULATORY PROBLEMS         |
| <input type="checkbox"/> PACEMAKER            | <input type="checkbox"/> SINUS PROBLEMS           | <input type="checkbox"/> NERVOUS PROBLEMS             |
| <input type="checkbox"/> ORGAN TRANSPLANT     | <input type="checkbox"/> HIGH BLOOD PRESSURE      | <input type="checkbox"/> RADIATION TREATMENTS         |
| <input type="checkbox"/> OPEN HEART SURGERY   | <input type="checkbox"/> LOW BLOOD PRESSURE       | <input type="checkbox"/> PSYCHIATRIC CARE             |
| <input type="checkbox"/> MITRO VALVE PROLAPSE | <input type="checkbox"/> EPILEPSY                 | <input type="checkbox"/> BIRTH CONTROL PILLS/IMPLANTS |
| <input type="checkbox"/> USED COCAINE         | <input type="checkbox"/> EXCESSIVE BLEEDING       | <input type="checkbox"/> CHRONIC HEADACHE             |
| <input type="checkbox"/> ANEMIA               | <input type="checkbox"/> HIP OR JOINT REPLACEMENT | <input type="checkbox"/> DIABETES                     |
| <input type="checkbox"/> ARTHRITIS            | <input type="checkbox"/> MEASLES                  | <input type="checkbox"/> HEPATITIS TYPE _____         |
| <input type="checkbox"/> ASTHMA               | <input type="checkbox"/> MUMPS                    | <input type="checkbox"/> MALIGNANCIES (CANCER)        |
| <input type="checkbox"/> HERPES               | <input type="checkbox"/> SCARLET FEVER            | <input type="checkbox"/> TUBERCULOSIS                 |
| <input type="checkbox"/> HIV POSITIVE         | <input type="checkbox"/> VENEREAL DISEASES        | <input type="checkbox"/> ULCER                        |
| <input type="checkbox"/> KIDNEY DISEASE       | <input type="checkbox"/> LIVER DISEASE            | <input type="checkbox"/> AIDS                         |
| <input type="checkbox"/> RESPIRATORY PROBLEMS | <input type="checkbox"/> SHORTNESS OF BREATH      | <input type="checkbox"/> JAW PAIN                     |
|                                               |                                                   | <input type="checkbox"/> FAINTING OR DIZZINESS        |

ARE YOU PREGNANT? \_\_\_\_\_

ARE YOU HAVING ANY DISCOMFORT AT THIS TIME? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

HOW LONG SINCE YOU HAVE BEEN TO A DENTIST? \_\_\_\_\_ ANY COMPLICATIONS WITH:

EXTRACTIONS \_\_\_\_\_  
ROOT CANALS \_\_\_\_\_  
DENTURES \_\_\_\_\_  
PARTIALS \_\_\_\_\_

IF ANY OF YOUR DENTAL PROBLEMS ARE DUE TO AN INJURY, WHAT WAS THE INJURY?

WHEN? \_\_\_\_\_

IF WEARING DENTURES OR PARTIALS, HOW OLD ARE THEY? \_\_\_\_\_

IF YOU HAVE ANY MISSING TEETH, WHEN WAS YOUR LAST EXTRACTION? \_\_\_\_\_

ANY PROBLEMS WITH DENTISTS OR DENTAL TREATMENT IN THE PAST \_\_\_\_\_

LIST MEDICATIONS YOU ARE CURRENTLY TAKING (GIVE REASON) \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_