DREAM SMILE DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ❑ M ❑ F Age _____

Birthdate _____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? ❑ Self ❑ Other

Relationship to Patient (if other) _____

Subscriber's Name (if other) _____

Insurance Co. _____

Group # _____

Birthdate _____ SS# _____

Is patient covered by additional Insurance? ❑ Yes ❑ No

Subscriber's Name: _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with

_____ **and assign directly to**
Name of Insurance Company(ies)

Dr. Dipali Dave all Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am fully 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-names 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.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (____) _____ Work (____) _____ Ext _____ Cell Phone (____) _____

Spouses's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Check "yes" or "no" to indicate if you have had any of the following:

Bad breath	❑ Yes	❑ No
Bleeding gums	❑ Yes	❑ No
Blisters on lips or mouth	❑ Yes	❑ No
Burning sensation on tongue	❑ Yes	❑ No
Chew on one side of mouth	❑ Yes	❑ No
Cigarette, pipe, or cigar smoking	❑ Yes	❑ No
Clicking or popping jaw	❑ Yes	❑ No
Dry mouth	❑ Yes	❑ No
Fingernail biting	❑ Yes	❑ No
Food collection between teeth	❑ Yes	❑ No
Foreign objects	❑ Yes	❑ No
Grinding teeth	❑ Yes	❑ No
Gums swollen or tender	❑ Yes	❑ No
Jaw pain or tiredness	❑ Yes	❑ No
Lip or Cheek biting	❑ Yes	❑ No
Loose teeth or broken fillings	❑ Yes	❑ No
Mouth breathing	❑ Yes	❑ No
Mouth pain, brushing	❑ Yes	❑ No
Orthodontic treatment	❑ Yes	❑ No
Pain around ear	❑ Yes	❑ No
Periodontal treatment	❑ Yes	❑ No
Sensitivity to cold	❑ Yes	❑ No
Sensitivity to heat	❑ Yes	❑ No
Sensitivity to sweets	❑ Yes	❑ No
Sensitivity when biting	❑ Yes	❑ No
Sores or growths in your mouth	❑ Yes	❑ No

How often do you floss? _____

How often do you brush? _____

- OVER -

DENTAL REGISTRATION AND HISTORY

5 PATIENT INFORMATION

Physician's Name _____ Date of last visit _____

Are you currently taking or have you taken any of the drugs collectively referred as "fen-phen?" (e.g. Iodimin, adiphex, fastin, pondimin, redux, etc.) ❑ Yes ❑ No

Are you currently taking or have you taken bisphosphonate medications such as Actonel, Bonefos, Boniva, Dional, or Fosamax? ❑ Yes ❑ No

Are you presently on blood thinners? ❑ Yes ❑ No

Please check "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Respiratory Disease	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Fainting or dizziness	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Arthritis, Rheumatism	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Artificial Heart Valves	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No
Artificial Joint	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Heart Problem	❑ Yes ❑ No	Skin Rash	❑ Yes ❑ No
Back Problems	❑ Yes ❑ No	Hepatitis Type _____	❑ Yes ❑ No	Special Diet	❑ Yes ❑ No
Bleeding abnormally, with extractions or surgery	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Steroid Therapy	❑ Yes ❑ No
		High Blood Pressure	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No	Swollen Feet or Ankles	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Jaw Pain	❑ Yes ❑ No	Swollen Neck Glands	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Circulatory Problems	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Congenital Heart Lesions	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No	Tumor or growth on head or neck	❑ Yes ❑ No
Cortisone Treatments	❑ Yes ❑ No	Nervous Problems	❑ Yes ❑ No		
Cough, persistent or bloody	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Ulcer	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No	Weight Loss, unexplained	❑ Yes ❑ No

Do you wear contact lenses? ❑ Yes ❑ No

Women:

Are you pregnant? ❑ Yes ❑ No Due date _____ Are you nursing? ❑ Yes ❑ No

Taking birth control pills? ❑ Yes ❑ No

MEDICATIONS

List any medications or vitamins you are currently taking and the correlating diagnosis:

_____

_____

I certify that I have read and understand the above and that the information is accurate and truthfull:

Patient's Signature _____ **Date** _____

Doctor's Signature _____ **Date** _____

ALLERGIES

❑ Yes ❑ No Aspirin		❑ Yes ❑ No Local Anesthesia	
❑ Yes ❑ No Barbiturates (Sleeping pills)		❑ Yes ❑ No Penicillin	
❑ Yes ❑ No Codeine		❑ Yes ❑ No Sulfa	
❑ Yes ❑ No Iodine		❑ Yes ❑ No Other _____	
❑ Yes ❑ No Latex		_____	

6 UPDATES *(To be filled in at future appointments)*

Has there been any changes in your health since your last dental appointment?

❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Medical Condition	Medical Condition	Medical Condition	Medical Condition	Medical Condition
Medical Update	Medical Update	Medical Update	Medical Update	Medical Update
Patient's Signature Date	Patient's Signature Date	Patient's Signature Date	Patient's Signature Date	Patient's Signature Date
X	X	X	X	X
Doctor's Signature Date	Doctor's Signature Date	Doctor's Signature Date	Doctor's Signature Date	Doctor's Signature Date
X	X	X	X	X