PATIENT REGISTRATION

DATE:___________

PATIENT INFORMATION

SS#____

Patient Name____

Address____

City____

State__________________________Zip Code________________

E-Mail____

Sex ☐ M ☐ F Age______________________

Birthdate____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Occupation____

Patient Employer/School_________________________________

Employer/School Address________________________________

Spouse's Name____

Spouse's Birthdate_______________________________________

Spouse's SS#____

Spouse's Employer______________________________________

Whom May We Thank for Referring You?_____________________

DENTAL INSURANCE

Responsible Party for this Account?__________________________

Relationship to Patient___________________________________

Insurance Company______________________________________

Group #____

Additional Insurance Coverage? Yes No

Subscriber's Name_______________________________________

Birthdate_________________ SS#____________________

ASSIGNMENT AND RELEASE

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

____

Name of Insurance Company

and assign directly to **Dr J Gary Williams, Dr Curtis A. Quigley or Today's Family 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 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

PHONE NUMBERS

Home (_______)_________________________Work (_______)________________________Cell (______)_______________________

Spouse'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 (_______)_____________________________________

DENTAL HISTORY

Reason for today's visit_________________

____

Former Dentist__________________________

City/State______________________________

Date of last dental visit_________________

Date of last X-rays_____________________

Circle "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 feeling on tongue	Yes	No
Chew on one side	Yes	No
Smoker	Yes	No
Clicking or popping jaw	Yes	No
Dry Mouth	Yes	No
Fingernail biting	Yes	No
Food collects 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 mouth	Yes	No

How often do you floss?________________

How often do you brush?_______________

PATIENT REGISTRATION

DATE:___________

HEALTH HISTORY

Physician's Name:____ Date of last visit:_______________________________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? ☐ Yes ☐ No

Please circle "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Epilepsy	Yes	No	Radiation Treatment	Yes	No
Anemia	Yes	No	Fainting or dizziness	Yes	No	Respiratory Disease	Yes	No
Arthritis, Rheumatism	Yes	No	Glaucoma	Yes	No	Rheumatic Fever	Yes	No
Artificial Heart Valves	Yes	No	Headaches	Yes	No	Scarlet Fever	Yes	No
Artificial Joints	Yes	No	Heart Murmur	Yes	No	Shortness of Breath	Yes	No
Asthma	Yes	No	Heart Problems	Yes	No	Sinus Trouble	Yes	No
Back Problems	Yes	No	Hepatitis TYPE_____	Yes	No	Skin Rash	Yes	No
Bleeding Abnormally	Yes	No	Herpes	Yes	No	Special Diet	Yes	No
Blood Disease	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Jaundice	Yes	No	Swollen Feet or Ankles	Yes	No
Chemical Dependency	Yes	No	Jaw Pain	Yes	No	Swollen Neck Glands	Yes	No
Chemotherapy	Yes	No	Kidney Disease	Yes	No	Thyroid Problems	Yes	No
Circulatory Problems	Yes	No	Liver Disease	Yes	No	Tonsillitis	Yes	No
Congenital Heart Problems	Yes	No	Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Cortisone Treatments	Yes	No	Mitral Valve Prolapse	Yes	No	Tumor or Growth on Head or Neck	Yes	No
Coughing	Yes	No	Nervous Problems	Yes	No	Ulcer	Yes	No
Diabetes	Yes	No	Pacemaker	Yes	No	Unexplained Weight Loss	Yes	No
Emphysema	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	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 you are currently taking and the reason for taking them:

____

____

____

____

Pharmacy Name____

Phone Number (_______)_________________________________

ALLERGIES

☐ Aspirin

☐ Local Anesthetic

☐ Barbiturates (Sleeping Pills)

☐ Penicillin

☐ Codeine

☐ Sulfa

☐ Iodine

☐ Other_____________

☐ Latex

____