

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? _____

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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

- | | |
|--------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |