MORESMILES DENTAL
PATIENT REGISTRATION AND MEDICAL HISTORY

Please fill out the following information. (Please print)

PATIENT: NAME_____ **DATE** _____

MAILING ADDRESS_____CITY_____ST_____ZIP_____

PHONE: Home _____ Work_____ext._____Cell_____

SEX ☐ M ☐ F AGE _____ DOB_____ S/S# (REQUIRED)_____/_____/_____

DRIVER'S LICENSE # *(REQUIRED)* _____ST_____

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

E-MAIL: _____ HOW DID YOU HEAR ABOUT US? _____

OCCUPATION _____EMPLOYER _____PHONE_____

SPOUSE'S NAME_____DOB_____S/S_____/_____/_____

PHONE Home _____ Work _____ext._____ Cell _____

WHO IS RESPONSIBLE FOR PAYMENT ON THIS ACCOUNT? _____REL. TO PATIENT _____

DENTAL INSURANCE PRIMARY INSURANCE CO.

_____INS.ID#_____Group#_____

INSURED'S NAME _____ REL. TO PATIENT _____

SECONDARY INSURANCE CO. _____ INS.ID#_____ Group#_____

SUBSCRIBER'S NAME _____ DOB _____

S/S/# _____/_____/_____ REL. TO PATIENT _____

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to MoreSmiles 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 hereby authorize the doctor to release all information necessary to secure the payments of benefits and authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature | Relationship | Date

DENTAL HISTORY

HAVE YOU EVER BEEN TOLD THAT PREMEDICATION IS REQUIRED FOR A DENTAL PROCEDURE? ☐ Yes ☐ No

REASON FOR TODAY'S VISIT:

_____

FORMER DENTIST _____ CITY _____ST_____ ZIP_____

DATE OF LAST DENTAL EXAM _____ DENTAL X-RAYS _____

Place a mark on "yes" or "no" to indicate if you have had any of the following

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

HEALTH HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST VISIT _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Radiation treatment	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Bleeding Abnormally with		Hepatitis Type	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen feet or ankles	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Swollen neck glands	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Circulatory problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Congenital heart lesions	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tumor/growth on head/neck	☐ Yes ☐ No
Cortisone treatments	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent/bloody	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Weight loss unexplained	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	H.P.V.	☐ Yes ☐ No
		Psychiatric Care	☐ Yes ☐ No	Guardasil Vaccination	☐ Yes ☐ No

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Is there anything else we should know about your medical history?

_____

FEMALES: Are you pregnant? ☐ Yes ☐ No Due Date: _____ Nursing? ☐ Yes ☐ No

Taking Birth Control Pills? ☐ Yes ☐ No Have you had a hysterectomy? ☐ Yes ☐ No

MEDICATIONS

Pharmacy Name: _____ Phone_____

Are you currently or have you ever taken any medications for osteoporosis? ☐ Yes ☐ No

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

_____

_____

List any herbs or vitamins you are currently using:

_____

ALLERGIES

Check any known allergies:

Aspirin ☐ Barbiturates (Sleeping Pills ☐ Codeine ☐ Epinephrine ☐ Food ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulfa ☐

Comments/ Other

_____

To the best of my knowledge the above information is complete and correct. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. I understand it is my responsibility to inform the dentist if I have a change in health.

_____ _____

Responsible Party Signature Date