PATIENT INFORMATION

Date_____

Name_____ Middle Initial_____ Birthdate_____ Sex_____

Mailing Address_____ City_____ State_____ Zip_____

Married____ Single___ SS#_____ Home Phone_____ Cell_____

Employer_____ Occupation_____ Work Phone_____

Spouses Name_____ Birthdate_____ Cell Phone_____

Spouses Employer_____ Occupation_____ Work Phone_____

If you have dental insurance please fill out the following:

Primary Insurance_____ Subscriber's name_____

Subscriber's Birthdate_____ Relation to patient_____ SS or ID#_____

Insurance Address_____ City_____ State_____ Zip_____

Phone_____ Group or Plan #_____

Is patient covered by additional dental insurance? Yes_____ No_____ If yes:

Secondary Insurance_____ Subscriber_____

Subscribers Birthdate_____ Relation to Patient_____ SS or ID#_____

Phone_____ Group or Plan #_____

In case of emergency whom should be notified? _____ Phone_____

Who will be responsible for this account?_____

I authorize treatment of the person named on this registration and agree to pay all fees and charges for such treatment as deemed necessary. I guarantee Dr. Trisha T. Goldsby payment of all charges for dental treatment and authorize payment to be made to her by my insurance co. The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of her staff responsible for any error or omissions that I may have made in the completion of this form.

Signature_____ Date_____

DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "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 the teeth	☐ Yes	☐ No
Foreign objects / Piercing	☐ 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? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations in the last 3 years? _____ If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ Acid Reflux	☐ Chest Pain	☐ Hemophilia	☐ Rheumatic Fever
☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Shortness of Breath
☐ Arthritis, Rheumatism	☐ Cough	☐ High Blood Pressure	☐ Sinus Problems
☐ Artificial Heart Valves	☐ Diabetes	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Dizziness	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcer

Do you have any other disease or medical problem not listed? ☐ Yes ☐ No Please explain: _____

_____

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone (____) _____

ALLERGIES

☐ Aspirin	☐ Sulfa
☐ Barbiturates (Sleeping pills)	☐ Latex _____
☐ Codeine	☐ Other _____
☐ Local Anesthetic	_____
☐ Penicillin	

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____