



# Dental Registration and History

Concerned Dental Care of Westchester PC **Patient Information**

**Dental Insurance**

Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
 Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

SS # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  
 Separated  Divorced  Partnered for \_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_  
 \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Patient ID# \_\_\_\_\_

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. \_\_\_\_\_ 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(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
 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 (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

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 dental X-rays \_\_\_\_\_

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

- |                                   |  |                                |  |
|-----------------------------------|--|--------------------------------|--|
| Bad Breath                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loose teeth or broken fillings | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Gums                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning sensation on tongue       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth pain, brushing           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cigarette, pipe, or cigar smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain around ear                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking or popping jaw           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal Treatment          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dry mouth                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to cold            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Periodontal treatment             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to heat            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Food collection between the teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to sweets          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Grinding teeth                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity when biting        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gums swollen or tender            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores or growths in your mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Jaw pain or tiredness             | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                |  |

# Health History

**Patient Name:** \_\_\_\_\_

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

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

HAVE YOU BEEN ADVISED BY YOUR PHYSICIAN THAT YOU NEEDED TO BE PRE-MEDICATED FOR DENTAL TREATMENT?  Yes  No

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

**Women:**

Are you pregnant?  Yes  No Due date \_\_\_\_\_ Are you nursing?  Yes  No  
Taking birth control pills?  Yes  No

**Medications**

Have you ever taken any of the following medications?  
FOSAMAX \_\_\_\_\_ BONIVA \_\_\_\_\_ ACTONEL \_\_\_\_\_

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

**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                         | _____                                     |

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

PATIENTS SIGNATURE \_\_\_\_\_ DOCTORS SIGNATURE \_\_\_\_\_

**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 \_\_\_\_\_

**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 \_\_\_\_\_