DENTAL REGISTRATION AND HISTORY

Watts Family Dental

Date: Home Phone ( ) Cell Phone ( )

PATIENT INFORMATION

Last Name First Name Middle Initial SS/HIC/Patient ID#

Address: Email:

City: State: Zip:

Sex ☐ M ☐ F Age: Birthdate:

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ___ years

Employer/School Occupation

Employer/School Address Employer/School Phone ( )

Whom may we thank for referring you?

In case of emergency, who should be notified? Phone ( )

PRIMARY INSURANCE

Person Responsible for Account
Last Name First Name Middle Initial

Relation to Patient Birthdate SSN

Address (if different from patient's) Phone ( )

City State Zip

Person Responsible Employed By State Zip

Business Address Business Phone ( )

Insurance Company

Contract # Group # Subscriber #

Names of other dependents covered under this plan

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name Birthdate Relation to Patient

Address (if different from patient's) Phone ( )

City State Zip

Subscriber Employed By State Zip

Business Address Business Phone ( )

Insurance Company SSN

Contract # Group # Subscriber #

Names of other dependents covered under this plan

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with Insurance Company(ies) named _____ and assign directly to Douglas Watts, DDS 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 doctor 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 Date

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Watts Family Dental

DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____ State _____ Zip _____

Check if you have had problems with any of the following

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking/Popping Jaw
- ☐ Food collection between teeth
- ☐ Grinding Teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively known as "fen-phen?" These include combniations of lonimon, Adipex, Fastin (brand names of phentermine), Pondium (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If Yes, please describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If Yes, please describe _____

Women, Check all that apply. I am: ☐ Pregnant ☐ Nursing ☐ Taking Birth Control Pills

Check if you have had problems with any of the following

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

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone ( ) _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbituates (Sleeping Pills)
- ☐ Codiene
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other _____

SIGNATURE

The above-named doctor 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 Date