DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date: _____

Patient Name:

_____

First Name *Middle Initial* *Last Name*

Patient Date of Birth: _____

Patient SS#: _____

Address: _____

_____

City *State* *Zip Code*

Home Phone Number: _____

Cell Phone Number: _____

Work Number: _____ *Ext* _____

Best time and place to reach you:

_____

Employer/School: _____

Occupation: _____

☐ Married ☐ Single ☐ Widowed ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for____*yrs*

***Who may we thank for referring you*?** _____

CONTACT - IN CASE OF AN EMERGENCY

Spouse's Name: _____

Home / Cell Number: _____

Work Number: _____ *Ext* _____

Specify someone who does not live in your household:

Name: _____ Relation _____

Home / Cell Number: _____

Work Number: _____ *Ext* _____

DENTAL INSURANCE

Who is responsible for this account?

_____

Relationship to Patient: _____

Primary Insurance CO: _____

Subscriber Name: _____

SS# or Insurance ID#: _____

Date of Birth: _____ Group #: _____

Relationship to Patient: _____

Secondary Insurance CO: _____

Subscriber Name: _____

SS# or Insurance ID#: _____

Date of Birth: _____ Group #: _____

Relationship to Patient: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have coverage with the above-named insurance companies and assign directly to: **Dr. Wael Alfy & Associates**, 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 **two years** 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*

DENTAL HISTORY

Reason for Today's Visit: _____ Date of Last Dental Visit: _____

Former Dentist: _____ City/State: _____

Are you under Orthodontic Care? ☐ YES ☐ NO Orthodontist Name: _____

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

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

Bad breath	☐ YES ☐ NO	Fingernail biting	☐ YES ☐ NO	Mouth breathing	☐ YES ☐ NO
Bleeding gums	☐ YES ☐ NO	Food collection	☐ YES ☐ NO	Mouth pain with brushing	☐ YES ☐ NO
Blisters on lips or mouth	☐ YES ☐ NO	Foreign object	☐ YES ☐ NO	Pain around ear	☐ YES ☐ NO
Burning Sensation on tongue	☐ YES ☐ NO	Grinding teeth	☐ YES ☐ NO	Periodontal treatment	☐ YES ☐ NO
Chew on one side of mouth	☐ YES ☐ NO	Gums swollen or tender	☐ YES ☐ NO	Sensitivity to cold	☐ YES ☐ NO
Cigarette, pipe, or cigar smoking	☐ YES ☐ NO	Jaw pain or tiredness	☐ YES ☐ NO	Sensitivity to heat	☐ YES ☐ NO
Clicking or popping jaw	☐ YES ☐ NO	Lip or Cheek biting	☐ YES ☐ NO	Sensitivity when biting	☐ YES ☐ NO
Dry Mouth	☐ YES ☐ NO	Loose tooth/broken filling	☐ YES ☐ NO	Sores/growths in mouth	☐ YES ☐ NO

HEALTH HISTORY

Physician's Name: _____ **Date of Last Visit**: _____

Have you ever used a bisphosphonate medication?
Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ YES ☐ NO

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" *These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).* ☐ YES ☐ NO

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

AIDS/HIV	☐ YES ☐ NO	Epilepsy	☐ YES ☐ NO	Respiratory Disease	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Fainting or dizziness	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO
Arthritis/Rheumatism	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	Scarlet Fever	☐ YES ☐ NO
Artificial Heart Valves	☐ YES ☐ NO	Headaches	☐ YES ☐ NO	Shortness of Breath	☐ YES ☐ NO
Artificial Joints	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO	Sinus Trouble	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Heart Problems	☐ YES ☐ NO	Skin Rash	☐ YES ☐ NO
Back Problems	☐ YES ☐ NO	Hepatitis *Type*: ____	☐ YES ☐ NO	Special Diet	☐ YES ☐ NO
Bleeding abnormally,	☐ YES ☐ NO	Herpes	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
-after surgery or extraction		High Blood Pressure	☐ YES ☐ NO	Swollen Feet or Ankles	☐ YES ☐ NO
Blood disease	☐ YES ☐ NO	Jaundice	☐ YES ☐ NO	Swollen Neck Glands	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Jaw Pain	☐ YES ☐ NO	Thyroid Problems	☐ YES ☐ NO
Chemical Dependency	☐ YES ☐ NO	Kidney Disease	☐ YES ☐ NO	Tonsillitis	☐ YES ☐ NO
Chemotherapy	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Circulatory Problems	☐ YES ☐ NO	Low Blood Pressure	☐ YES ☐ NO	Tumor/Growth on	☐ YES ☐ NO
Congenital Heart Lesions	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO	*-head or neck*	
Cortisone Treatments	☐ YES ☐ NO	Nervous Problems	☐ YES ☐ NO	Ulcer	☐ YES ☐ NO
Cough: persistent/bloody	☐ YES ☐ NO	Pacemaker	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Psychiatric Care	☐ YES ☐ NO	Weight Loss,	☐ YES ☐ NO
Emphysema	☐ YES ☐ NO	Radiation Treatment	☐ YES ☐ NO	*-unexplained*	

FOR WOMEN ONLY: Are you taking Birth Control pills? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO Due Date: _____ Are you nursing? ☐ YES ☐ NO

MEDICATIONS

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

_____

_____

Pharmacy Name: _____

Phone Number: _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic
☐ Codeine ☐ Penicillin
☐ Iodine ☐ Sulfa
☐ Latex
☐ Sleeping Pills/Barbiturates
☐ Other: _____

Patient's Signature: X _____ **Date**: _____

Doctor's Signature: _____ **Date**: _____

UPDATE

Has there been any change in your health since your last dental appointment? ☐ YES ☐ NO

For what conditions? _____

Are you taking any new medications? ☐ YES ☐ NO If so, what? _____

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

UPDATE

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For what conditions? _____

Are you taking any new medications? ☐ YES ☐ NO If so, what? _____

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____