DENTAL REGISTRATION AND HISTORY

DATIENT INCODMATIC	NI 9	DENTA	I INCIDANCE				
PATIENT INFORMATION		DENTA	AL INSURANCE				
Date		Who is resp	onsible for this account?				
SS/HIC/Patient ID #	Rel	lationship to Patier	nt				
Patient Name	Insu	urance Co					
Last Name	Gro	oup #					
First Name			additional insurance? Yes	1			
Address				1			
E-mail			SS#				
				- 1			
City	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		nt	1			
StateZip	Inst	urance Co					
Sex M F Age	Gro	oup #					
Birthdate		SIGNMENT AND RE	ELEASE or my dependent(s), have insurance	ce coverage with			
☐ Married ☐ Widowed ☐ Single	☐ Minor	ertify that i, and/c		assign directly to			
☐ Separated ☐ Divorced ☐ Partnered for	or years		urance Company(ies)	and an oddy to			
Patient Employer/School	Dr	Dr. PAPA, Northwest Dental LTD all insurance benefits, if					
Occupation	any,		to me for services rendered. I und or all charges whether or not paid by ins	erstand that I am			
Employer/School Address		the use of my signature on all insurance submissions.					
	The		st may use my health care information above-named Insurance Company(les				
Employer/School Phone ()	for	the purpose of obta	aining payment for services and deter payable for related services. This con-	ermining insurance			
	my		an is completed or one year from the d				
Spouse's Name							
Birthdate		Signature of Pati	ent, Parent, Guardian or Personal Rep	resentative			
SS#		Please print name of	Patient, Parent, Guardian or Personal	Representative			
Spouse's Employer		, ,					
Whom may we thank for referring you?		Date	Relationship to	Patient			
PHONE NUMBERS							
Phone ()	Work (Ext	Cell ()				
Spouse's Work () IN CASE OF EMERGENCY, CONTACT (Specify s							
			· ·	ľ			
Name							
Home Phone ()	VVOTK P	-none ()					
DENTAL HISTORY							
DENIAL HISTORY							
Reason for today's visit	Burning sensation on tongue	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No ☐ Yes ☐ No			
	Chew on one side of mouth Cigarette, pipe, or cigar smoking	☐ Yes ☐ No	Mouth pain, brushing Orthodontic treatment	Yes No			
Former Dentist	Clicking or popping jaw	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No			
City/State	Dry mouth	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No			
Date of last dental visit	Fingernail biting	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No			
Date of last dental X-rays	Food collection between the teeth Foreign objects	Yes No	Sensitivity to heat Sensitivity to sweets	☐ Yes ☐ No			
Place a mark on "yes" or "no" to indicate if you	Grinding teeth	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No			
have had any of the following:	Gums swollen or tender	☐ Yes ☐ No	Sores or growths in your mouth	☐ Yes ☐ No			
Bad breath Yes No	Jaw pain or tiredness	☐ Yes ☐ No	How often do you floss?				
Bleeding gums Yes No Blisters on lips or mouth Yes No	Lip or cheek biting Loose teeth or broken fillings	☐ Yes ☐ No ☐ Yes ☐ No	How often do you brush?				
Blisters on lips or mouth Yes No	Loose teeth of broken minigs						

Physician Name Area you ever tused a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Distonel, Bohria, Ison No Hase you ever tused a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Distonel, Bohria, Ison No Hase you ever tused a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Distonel, Bohria, Isonelium, Iso	green The	Spirit Artis				The plan		Janes of ph	1
Have you ever taken any of the group of druge collectively referred to as "fen-phen?" These include combinations of lonimin, Adipse, Fastin (branchamens) phantermine), Proderim (Nentirumnine) and Redux (deshefulamine). [1968] No.		No Part No.				2043	NAME OF TAXABLE PARTY OF TAXABLE PARTY.		-
names of phentermine), Produintin (fenfluramine) and Redux (dexcelluramine). Yes No Places a mark on yes of "not to inclinate if you have held any of the following: AlbS/HV	A LOVE OF						A An	Manus mention in	
AlDSHIV	dimin (fen	fluramine) a	nd Redux (dexfenfluramin	ne). 🗌 Y			mbinations of Ionimin, Adipex, Fa	astin (brand	d
Anemia				g:	141				
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Artificial Joints	C. LaConsolitore	HEROLD PROPERTY.			140	A 1983 N. L.		☐ Yes	
No No No No No No No No					Yes	The Control of		Yes	
No.	17 - 197, 100 III	156			97. 41.13	one state of the state of		☐ Yes	
Sack Problems	(435)				100	- Land 1972			
Slaeding abnormally, with Yes No									
extractions or surgery High Blood Pressure							. It is the second second		_
Slood Disease Yes No	Yes	∐ No	7.3.49 T						
Cancer Yes No	□ Voc	□ No							
Chemical Dependency Yes No	The state of	THE PROPERTY LAND							
Chemotherapy Yes No Liver Disease Yes No Tuberculosis Yes Mo Corporative Problems Yes No Liver Disease Yes No Tuberculosis Yes Yes Yes No Tuberculosis Yes Yes No Tuberculosis Yes Yes No Yes Yes Yes Yes Yes Yes No Yes		10 H (F) M				V			-
Circulatory Problems						The state of the s			
Congenital Heart Lesions Yes No Mitral Valve Prolapse Yes No North Transport Yes Nort		Branch and March Admin	4.7						1
Cortisone Treatments	and THE STATE OF THE	Total Control Control	Add to the second secon			1.0	9	∐ Yes	
Cough, persistent or bloody Yes No Pacemaker Yes No Venereal Disease Yes No Diabetes Yes No Pacemaker Yes No Weight Loss, unexplained Yes No Pacemaker Yes No Weight Loss, unexplained Yes No Pacemaker Yes No Weight Loss, unexplained Yes No Pacemaker Yes No Nomen: Are you pregnant? Yes No No Momen: Are you pregnant? Yes No Due date Are you nursing? Yes No MEDICATIONS ALLERGIES Aspirin Local Anesthetic Barbiturates (Sleeping pills) Penicillin Codeine Sulfa Didine Other Penarmacy Name Indiana Indian	Visit Resident	County By Indian In						□ Ves	
Diabetes Yes No					10 TO 10 TO 11				1
Emphysema					alan a district	Commission of the Party of the	A framework	_	
Do you wear contact lenses? Yes No Nomen: Are you pregnant? Yes No Due date Are you nursing? Yes No MEDICATIONS ALLERGIES	10015000					CALLED SON OF A ST	Weight Loss, unexplained	L 163	_ '
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Barbiturates (Sleeping pills) Penicillin Codeline Sulfa Indiana Debarmacy Name Indiana Ind	currently	taking and t	he correlating		nirin	Addres V	□ Local Apactheti		
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Pharmacy Name				and the second					
Pharmacy Name				□Ва	rbiturate	es (Sleepin	g pills) 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? \ If so, what? \ Patient's Signature \ Date \ Da	The state of	The second second				es (Sleepin	- C 10 14		
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Has there been any change in your health since your last dental appointment? _ Yes _ No For what conditions?					deine	es (Sleepin	☐ Sulfa		
Are you taking any new medications? If so, what? Date	A Company			□ Co	deine	es (Sleepin	☐ Sulfa		
Are you taking any new medications? If so, what? Date	(To be	filled in a	at future appointmen	☐ Co☐ loo	deine dine tex		☐ Sulfa		
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Doctor's Signature	(To be	filled in a	at future appointmer th since your last dental a	Coc La	deine dine tex	Yes 🗀 I	☐ Sulfa		
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