

## PATIENT REGISTRATION

Patient's Name: \_\_\_\_\_ Nickname \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Marital Status: Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_  
Cell # \_\_\_\_\_ E-mail: \_\_\_\_\_

Father's Name: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Marital Status: Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_  
Cell # \_\_\_\_\_ E-mail: \_\_\_\_\_  
Names and Birthdates of Siblings: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_  
Their Address: \_\_\_\_\_

## INSURANCE INFORMATION

Does the patient have dental insurance? Y / N      If yes, please complete the following:

Primary Policy Holder: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Employer: \_\_\_\_\_ Group or Policy Number: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_ Claims Phone Number: \_\_\_\_\_  
Address to Send Claim: \_\_\_\_\_

Secondary Policy Holder: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Employer: \_\_\_\_\_ Group or Policy Number: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_ Claims Phone Number: \_\_\_\_\_  
Address to Send Claim: \_\_\_\_\_

Does the patient have medical insurance? Y / N      If yes, please complete the following:

Policy Holder: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Employer: \_\_\_\_\_ Group or Policy Number: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_ Claims Phone Number: \_\_\_\_\_  
Address to Send Claim: \_\_\_\_\_

## MEDICAL HISTORY

Patient's Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Date of last medical visit: \_\_\_\_\_ Purpose: \_\_\_\_\_ Findings: \_\_\_\_\_  
Is the patient under the care of a physician at this time? Y / N  
If yes, for what reason? \_\_\_\_\_

Is the patient currently taking **any** medication? Y / N If yes, please complete the following:  
Medication: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_  
Dosage: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_  
Frequency: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_  
Reason: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

Has the patient ever had any unusual or allergic reactions to medications or food? Y / N  
If yes, please complete the following: Medications: \_\_\_\_\_  
Foods: \_\_\_\_\_ Other: \_\_\_\_\_

Does the patient have a latex allergy or sensitivity? Y / N

Has the patient ever been told they have a heart murmur or evidence of heart disease? Y / N  
If yes, please describe: \_\_\_\_\_  
Has the patient ever been told they need to take antibiotics prior to dental treatment, due to their heart condition? Y / N

Were there any problems associated with the pregnancy or birth of the patient? Y / N  
If yes, please describe: \_\_\_\_\_  
Has the patient **ever** been hospitalized? Y / N  
If yes, please describe: \_\_\_\_\_

Has the patient had **any** operations or surgical procedures? Y / N  
If yes, please describe: \_\_\_\_\_

Does the patient have any behavioral, emotional, or developmental problems? Y / N  
If yes, please describe: \_\_\_\_\_

**Does the patient have a history of any of the following? Please respond either Y or N**

<input type="checkbox"/> AIDS/HIV Testing	<input type="checkbox"/> Depression	<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Anemia/Blood Disorder	<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Organ Transplant
<input type="checkbox"/> Artificial Prosthesis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Persistent Cough
<input type="checkbox"/> Asthma/Respiratory Problems	<input type="checkbox"/> Headaches	<input type="checkbox"/> Psychological Problems
<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Hepatitis Vaccine	<input type="checkbox"/> Speech/Hearing Problems
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> TB Test/Disease
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Kidney/Bladder Problems	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Liver Problems/Jaundice	<input type="checkbox"/> Other Problems/Illnesses
<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Malignancies	

## DENTAL HISTORY

What is the purpose of this appointment? \_\_\_\_\_  
Has the patient ever been to a dentist prior to today's visit? Y / N If yes, please complete:  
Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Date of last dental visit: \_\_\_\_\_ Purpose of last dental visit: \_\_\_\_\_  
Why have you decided to change dentists? \_\_\_\_\_  
How do you expect your child to react to today's visit? \_\_\_\_\_

## ORAL HYGIENE

Does the patient brush their own teeth? Y / N When? \_\_\_\_\_  
Do you assist the patient in brushing? Y / N When? \_\_\_\_\_  
Is dental floss used in cleaning the patient's teeth? Y / N Frequency: \_\_\_\_\_

**FLUORIDE**

Do you have a well or public water? \_\_\_\_\_  
Is the patient currently taking fluoride supplements? Y / N If yes, please complete:  
Brand of supplement: \_\_\_\_\_ Dosage: \_\_\_\_\_  
Has the patient ever taken fluoride supplements? Y / N If yes, please complete:  
Brand of supplement: \_\_\_\_\_ Dosage: \_\_\_\_\_  
Age of patient while taking supplements: \_\_\_\_\_ Why discontinued: \_\_\_\_\_  
Has the patient ever received topical fluoride application? Y / N If yes, please complete:  
Dentist applied \_\_\_\_\_ Home rinse \_\_\_\_\_ School rinse \_\_\_\_\_ Brush on Rx \_\_\_\_\_  
Does the patient use toothpaste? Y / N If yes, what brand? \_\_\_\_\_

**ORAL HABITS**

Does the patient have a history of any of the following habits? If yes, please complete:  
Taking bottle to bed at night or naptime? Y / N Until what age? \_\_\_\_\_  
What was in the bottle? \_\_\_\_\_  
Pacifier? Y / N Habit Pattern: \_\_\_\_\_ Until what age? \_\_\_\_\_  
Finger/thumb sucker? Y / N Habit Pattern: \_\_\_\_\_ Until what age? \_\_\_\_\_  
Tongue thrust? Y / N Habit Pattern: \_\_\_\_\_ Until what age? \_\_\_\_\_  
Mouth breather? Y / N Habit Pattern: \_\_\_\_\_ Until what age? \_\_\_\_\_  
Tooth grinding? Y / N Habit Pattern: \_\_\_\_\_ Until what age? \_\_\_\_\_  
Fingernail biting? Y / N Habit Pattern: \_\_\_\_\_ Until what age? \_\_\_\_\_

**ORAL TRAUMA**

Has the patient's teeth ever been injured? Y / N  
If yes, please describe: \_\_\_\_\_  
Did the injury receive any medical or dental treatment? Y / N  
If yes, please describe: \_\_\_\_\_  
Has there ever been any injury to the patient's face or jaws? Y / N  
If yes, please describe: \_\_\_\_\_  
Does the patient complain of clicking, popping, or crunching noises when they chew? Y / N  
Has the patient's jaw ever locked open or closed? Y / N  
Has the patient ever experienced any limitations in jaw opening, or pain when opening? Y / N

**CONSENT FOR TREATMENT**

To the best of my knowledge, all of the preceding answers are true and correct. If there is ever a change in the patients health and/or medications I will inform the office. I agree to update the patient's health history as requested.

I have the legal authority to grant consent for services for the above named patient.

I give my consent for dental services to be rendered for the above named patient.

In consideration of services to be rendered, I guarantee payment of all charges incurred by the patient. I understand that I am responsible for any insurance deductibles and copayments. Delinquent accounts are subject to costs of collection. This includes, but is not limited to attorneys' fees of 20% and costs of collection. I authorize Dr. Blumenthal to release any information regarding charges incurred by this patient.

Date \_\_\_\_\_ Signature \_\_\_\_\_ Relation to patient \_\_\_\_\_

**OFFICE USE ONLY**



I acknowledge receipt of the Notice of Privacy Practices for Stuart D. Blumenthal DDS, PA

Reviewed By:

Date: