DENTAL REGISTRATION AND HISTORY

	ON	DEN	TAL INSURANCE	emis/A a'nsiple.		
Date	A POR A TRANSPORTATION OF THE PROPERTY OF THE	/ho is responsible	e for this account?			
SS/HIC/Patient ID #		The state of the s	atient			
Brown Wilderson TT Viscon						
Patient NameLast Name						
First Name	Middle Initial	The state of the s		COMPANY OF STREET		
Address	ls ls	patient covered	by additional insurance? Yes	□No		
E-mail	S	ubscriber's Nam	e	Smal tabi		
	B	irthdate	SS#			
City	R	elationship to Pa	atient	Somete on a		
State Zip	In	surance Co	er visa	Crise to enotice th		
Sex M F Age		Group #				
Birthdate		SSIGNMENT AND		estructe Circum		
☐ Married ☐ Widowed ☐ Single			nd/or my dependent(s), have insurar	nce coverage wit		
☐ Separated ☐ Divorced ☐ Partnered for	or years	Name of	Insurance Company(ies) an	nd assign directly to		
Patient Employer/School						
Occupation	U	r ny, otherwise paya	all in the services rendered. I un	nsurance benefits, derstand that I ar		
	fir	nancially responsible	e for all charges whether or not paid by in ure on all insurance submissions.			
Employer/School Address			entist may use my health care information	on and may disclose		
	sı	uch information to	the above-named Insurance Company(is	es) and their agent		
Employer/School Phone ()	be	enefits or the bene	obtaining payment for services and del fits payable for related services. This con	nsent will end whe		
Spouse's Name	m	y current treatment	plan is completed or one year from the	date signed below.		
Birthdate			Self Company College			
		Signature of I	Patient, Parent, Guardian or Personal Re	presentative		
00#						
SS#Snouse's Employer		Please print name	of Patient, Parent, Guardian or Persona	I Representative		
Spouse's Employer		Please print name	e of Patient, Parent, Guardian or Persona	al Representative		
Spouse's Employer		Please print name	e of Patient, Parent, Guardian or Persona Relationship t			
Spouse's Employer		and distribution	ET STEEN DIE EN ER DE DE			
Spouse's Employer	E E E	Date	ET STEEN DIE EN ER DE DE	to Patient		
Spouse's Employer	Work ()	Date Ext	Relationship t	to Patient		
Spouse's Employer	Work () Best time and place to reach yo	Date Ext	Relationship t	to Patient		
Spouse's Employer	Work () Best time and place to reach you omeone who does not live in you	Date Ext bu ur household.)	Relationship t	to Patient		
Spouse's Employer	Work () Best time and place to reach you omeone who does not live in you Relati	Date Ext ou_ ur household.)	Relationship t	to Patient		
Spouse's Employer	Work () Best time and place to reach you omeone who does not live in you Relati	Date Ext ou_ ur household.)	Relationship t	to Patient		
Spouse's Employer	Work () Best time and place to reach you omeone who does not live in you Relati	Date Ext ou_ ur household.)	Relationship t	to Patient		
Spouse's Employer	Work () Best time and place to reach you omeone who does not live in you Relati Work Burning sensation on tongue	Date Ext bu ur household.) ionship Phone ()	Relationship to Relationship t	to Patient		
Spouse's Employer	Work () Best time and place to reach you omeone who does not live in you Relati Work Burning sensation on tongue Chew on one side of mouth	Date Ext ou ur household.) ionship Phone () Yes	Relationship to Relationship to Mouth breathing Mouth pain, brushing	to Patient Yes No		
PHONE NUMBERS PHONE NUMBERS Home ()	Work () Best time and place to reach you omeone who does not live in you Relating Work Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking	Ext Date Ext bu ur household.) ionship Phone () Yes	Relationship to Relationship to Mouth breathing Mouth pain, brushing Orthodontic treatment	to Patient Yes No Yes No		
Whom may we thank for referring you? PHONE NUMBERS Home () N CASE OF EMERGENCY, CONTACT (Specify solution of the content of the conten	Work () Best time and place to reach you omeone who does not live in you Relating Work Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw	Date Ext ou ur household.) ionship Phone () Yes No Yes No Yes No Yes No	Relationship to Relationship to Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear	Tyes No Yes No Yes No		
Whom may we thank for referring you? PHONE NUMBERS Home () Spouse's Work () IN CASE OF EMERGENCY, CONTACT (Specify solution) Home Phone () DENTAL HISTORY Reason for today's visit Former Dentist City/State	Work () Best time and place to reach you omeone who does not live in you Relating Work Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking	Ext Date Ext bu ur household.) ionship Phone () Yes	Relationship to Relationship t	Tyes No Yes No Yes No Yes No		
Whom may we thank for referring you? PHONE NUMBERS Home () Spouse's Work () IN CASE OF EMERGENCY, CONTACT (Specify solution) Home Phone () DENTAL HISTORY Reason for today's visit Former Dentist City/State	Work () Best time and place to reach you omeone who does not live in you Relating Work Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth	Date Ext Du ur household.) ionship Phone () Yes No	Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold	Yes No Yes No Yes No Yes No		
PHONE NUMBERS PHONE NUMBERS Home () Spouse's Work () N CASE OF EMERGENCY, CONTACT (Specify selection) DENTAL HISTORY Reason for today's visit Former Dentist City/State Date of last dental visit	Work () Best time and place to reach you omeone who does not live in you Relating Work Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth Fingernail biting	Date Ext Du ur household.) ionship Phone () Yes No	Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat Sensitivity to sweets	Tyes No Yes No Yes No Yes No Yes No Yes No		
PHONE NUMBERS PHONE NUMBERS Home () N CASE OF EMERGENCY, CONTACT (Specify selected by selected	Work () Best time and place to reach you omeone who does not live in you reach work Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth Fingernail biting Food collection between the teeth Foreign objects Grinding teeth	Date Ext	Relationship to Relationship to Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat Sensitivity to sweets Sensitivity when biting	Yes No Yes Yes		
Spouse's Employer	Work () Best time and place to reach you omeone who does not live in you Relating Work Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth Fingernail biting Food collection between the teeth Foreign objects Grinding teeth Gums swollen or tender	Date	Relationship to Relationship t	Yes No Yes Yes No Yes Yes No Yes Yes		
Spouse's Employer	Work () Best time and place to reach you omeone who does not live in you reach work Burning sensation on tongue Chew on one side of mouth Cigarette, pipe, or cigar smoking Clicking or popping jaw Dry mouth Fingernail biting Food collection between the teeth Foreign objects Grinding teeth	Date Ext	Mouth breathing Mouth pain, brushing Orthodontic treatment Pain around ear Periodontal treatment Sensitivity to cold Sensitivity to heat Sensitivity to sweets Sensitivity when biting Sores or growths in your mouth How often do you floss?	Tyes No Yes No		

Physician's Name						Date of	last visit	BITA	200.000		
Have you ever taken any of the			ollectively referred to as "fe	n-phen?" These	include co		that the same of t	astin (brai	nd		
names of phentermine), Pond	dimin (fen	fluramine)	and Redux (dexfenfluramin	ne). 🗌 Yes 🔲] No						
Place a mark on "yes" or "no"	to indica	te if you ha	ave had any of the following	g:							
AIDS/HIV	Yes	□No	Epilepsy	☐ Yes	☐ No	Respirat	tory Disease	☐ Yes			
Anemia	☐ Yes	□No	Fainting or dizziness	☐ Yes	□ No	Rheuma	atic Fever	Yes			
Arthritis, Rheumatism	Yes	□No	Glaucoma	☐ Yes	□ No	Scarlet I	Fever	Yes			
Artificial Heart Valves	Yes	□No	Headaches	Yes	□No	Shortne	ss of Breath	☐ Yes			
Artificial Joints	Yes	□No	Heart Murmur	Yes	□ No	Sinus Tr	ouble	☐ Yes			
Asthma		□No	Heart Problems	Yes	□No	Skin Ra	sh	☐ Yes			
Back Problems	Yes	□No	Hepatitis Type	Yes	□No	Special	Diet	☐ Yes			
Bleeding abnormally, with	Yes	□No	Herpes	Yes	□No	Stroke		Yes			
extractions or surgery			High Blood Pressure	☐ Yes	□No	Swollen	Feet or Ankles	Yes			
Blood Disease	Yes	□ No	Jaundice	The second secon	□No	Swollen	Neck Glands	Yes			
Cancer	☐ Yes	□No	Jaw Pain		П No	Thyroid	Problems	☐Yes			
Chemical Dependency	Yes	□ No	Kidney Disease		□No	Tonsillitis		Yes			
Chemotherapy	Yes	□ No	Liver Disease		□No	Tubercu					
Circulatory Problems	☐Yes	□No	Low Blood Pressure	☐ Yes	□No		r growth on head or	☐ Yes			
Congenital Heart Lesions	☐ Yes	□No				neck	grown on nead of	LITES			
Cortisone Treatments	☐ Yes	□No	Mitral Valve Prolapse	Yes	□ No	Ulcer		☐ Yes			
Cough, persistent or bloody		□ No	Nervous Problems	☐Yes	□ No		Il Disease	☐Yes			
Diabetes	☐ Yes	□No	Pacemaker	☐ Yes			Loss, unexplained				
			Psychiatric Care		□ No	vveignt i	Loss, unexplained	□ 163	П.		
Emphysema	Yes	□ No	Radiation Treatment	Yes	□ No						
Oo you wear contact lenses? Nomen: Are you pregnant? Taking birth control pills?	□No	□ No	Due date		Are you no	ursing? 🗌 Ye	es 🗆 No				
Taking birth control pills? Yes No MEDICATIONS			ALLERGIES								
ist any medications you are	currently	taking and	the correlating diagno-	Aspirin Local Anesthetic							
ist any medications you are currently taking and the correlating diagno- sis:						Tury president of shert everyone					
· Major I di di sabibi	#17 			☐ Barbiturate	es (Sleepir	ng pilis)	☐ Penicillin				
				☐ Codeine			☐ Sulfa				
Pharmacy Name				□ lodine			Other				
	Phone ()										
Filotie ()				Latex				and the state of	Volum		
3			Apprenant rock	rii avli ton seus	color descri	plac (does,8)		HALL DE	Hay		
UPDATES	(To be	filled in	at future appointmen	nts)							
Has there been any change i											
For what conditions?								1 19 3 1			
	ications?		If so, what?		Bio Soan		lie/v	e projection of			
64 36/12 56/12						Date					
	Actions.						Date				
Patient's Signature	Actions.		AND	Ballett O K Cigar Co. Les agos ent Co. Les agos ente	ap Asaveg		Date				
Patient's Signature Doctor's Signature	ACCURATE TO THE PROPERTY OF TH	a ağııcıbon a Dingilia e		que, en arque entre depende pare	in_1%ere and p ease		Date				
Patient's Signature Doctor's Signature				Wall Charles		••••••	Date		••••		
Patient's Signature Doctor's Signature Has there been any change i	in your he	ealth since	your last dental appointme	Wall Charles		•••••	Date		est to		
Patient's Signature Doctor's Signature Has there been any change in the street of the	in your he	ealth since	your last dental appointme	nt? 🗆 Yes 🗆	l No	A LEXY II	Date				
Patient's Signature Doctor's Signature Has there been any change if the street of the	in your he	ealth since	your last dental appointme	nt? Yes	l No		Date				
Are you taking any new medi Patient's Signature Doctor's Signature Has there been any change i For what conditions? Are you taking any new medi Patient's Signature Doctor's Signature	in your he	ealth since	your last dental appointme	nt? Yes] No		Date	Listone A	est ju		