DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date: _____
SSN: _____
Last Name: _____
First Name: _____
Birthdate: _____ Age: _____
Sex: ☐ M ☐ F
☐ Married ☐ Single ☐ Minor

Address: _____
City: _____
State: _____ Zip: _____
E-mail: _____
Home Phone: _____
Mobile Phone: _____
Work Phone: _____

Emergency Contact:
Name: _____
Phone Number: _____
Relationship: _____

Whom may we thank for referring you?
_____

EMPLOYER

Occupation: _____
Employer/School: _____
Employer/School Phone: _____

Spouse's Name: _____
Birthdate: _____
SSN: _____
Spouse's Employer: _____

DENTAL INSURANCE

Subscriber's Name: _____
Birthdate: _____
SSN: _____
Relationship to Patient: _____

Insurance Company: _____
Employer: _____
Phone: _____
Group #_____
Subscriber ID: _____

DENTAL HISTORY

Reason for today's visit: _____
_____
Former Dentist: _____
Phone Number: _____
Date of Last Dental Visit: _____
Date of Last Dental X-rays: _____

Place a checkmark to indicate if you have had any of the following:

- ☐ Removable Appliances
- ☐ Sensitive Teeth
- ☐ Tobacco Use
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment
- ☐ Swelling
- ☐ Pain in Ear
- ☐ Sores on tongue or mouth
- ☐ Loose Teeth or Broken Fillings
- ☐ Dry Mouth
- ☐ Periodontal Treatment
- ☐ Cold Sensitivity
- ☐ Heat Sensitivity
- ☐ Clenching or Grinding

Do you prefer "laughing gas" for dental treatment? ☐ Yes ☐ No

Are you happy with your smile? ☐ Yes ☐ No

If no, please explain_____

Are you interested in orthodontics? ☐ Yes ☐ No

Are you interested in teeth whitening? ☐ Yes ☐ No

ROCKET CITY DENTAL
ROCKETCITYDENTAL.NET
(256) 881-4580

MEDICAL HISTORY

Physician's Name: _____ Date of last visit: _____

Does your physician recommend antibiotic premedication prior to dental treatment? ☐ Yes ☐ No

If yes, please explain _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva, Prolia.
☐ 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 checkmark to indicate if you have had any of the following:

☐ AIDS/HIV	☐ Fainting or dizziness	☐ Rheumatic Fever
☐ Anemia	☐ Glaucoma	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Headaches	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Heart Murmur	☐ Sinus Trouble
☐ Artificial Joints	☐ Heart Problems	☐ Skin Rash
☐ Asthma	☐ Hepatitis Type ___	☐ Special Diet
☐ Back Problems	☐ Herpes	☐ Stroke
☐ Bleeding Abnormally, with extractions or surgery	☐ High Blood Pressure	☐ Swollen Feet or Ankles
☐ Blood Disease	☐ Jaundice	☐ Swollen Neck Glands
☐ Cancer	☐ Jaw Pain	☐ Thyroid Problems
☐ Chemical Dependency	☐ Kidney Disease	☐ Tonsilitis
☐ Chemotherapy	☐ Liver Disease	☐ Tuberculosis
☐ Circulatory Problems	☐ Low Blood Pressure	☐ Tumor or growth on head or neck
☐ Congenital Heart Lesions	☐ Mitral Valve Prolapse	☐ Ulcer
☐ Cortisone Treatments	☐ Nervous Problems	☐ Venereal Disease
☐ Cough, persistent or bloody	☐ Pacemaker	☐ Wear Contact Lenses
☐ Diabetes	☐ Psychiatric Care	☐ Weight Loss, unexplained
☐ Emphysema	☐ Radiation Treatment	☐ Surgery _____
☐ Epilepsy	☐ Respiratory Disease	☐ Other _____

Women:
Are you pregnant? ☐ Yes ☐ No Due date: _____ Are you nursing? ☐ Yes ☐ No
Taking Birth Control Pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking:

_____
_____
_____
_____

Pharmacy Name: _____
Phone: _____

ALLERGIES

☐ Aspirin	☐ Local Anesthetic
☐ Barbiturates	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Iodine	☐ Other _____
☐ Latex	☐ _____

BY MY SIGNATURE BELOW, I CERTIFY THAT THE INFORMATION I PROVIDE ON AND IN CONNECTION WITH THIS FORM IS **TRUE AND CORRECT** TO THE BEST OF MY KNOWLEDGE. 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. ROCKET CITY DENTAL MAY USE MY HEALTHCARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENTS FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT IS COMPLETE OR ONE YEAR 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