

Orwick Dental Care, LLC

Dental Registration and History

Date: _____
 SS# _____ Birth date: _____

Patient Name: _____

 Last Name

First Name _____ Middle Initial _____

Address _____

 City State Zip

E-mail _____

Sex M F Age _____

Married Widowed Single
 Separated Divorced Minor

Patient Employer/School _____
 Occupation _____
 Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____
 SS# _____ Birth date _____

Spouse's Employer _____

Whom may we thank for referring you?

Who is responsible for this account?

Relationship to patient _____
 Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

SS# _____ Birth date _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
 Name of Insurance Co.

Dr. _____ 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 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

PHONE NUMBERS HOME _____ WORK _____ ext _____

Cell phone _____ Spouse's work _____ Best time and place to reach you? _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

DENTAL HISTORY Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last dental x-rays _____

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

Bad breathe yes no Burning sensation on tongue yes no Mouth breathing yes no

Bleeding gums yes no Chew on one side of mouth yes no Mouth pain, brushing yes no

Blisters on lips yes no Tobacco use yes no Orthodontics yes no

Dry Mouth yes no Fingernail biting yes no Pain around ear yes no

Grinding teeth yes no Gums swollen or tender yes no Jaw pain or tiredness yes no

Loose teeth yes no Broken fillings yes no Lip or cheek biting yes no

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

HEALTH HISTORY Physician's Name _____ Date of last Visit _____

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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally,
with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head
or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No
Taking birth control pills? Yes No

Due date _____

Are you nursing? Yes No

MEDICATIONS:

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

Do you take any herbal supplements? Yes No
If yes, please list: _____

Pharmacy Name: _____
Phone: _____

ALLERGIES:

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (sleeping pills) | |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Other _____ |
| | _____ |