Spencer & Kerby
Comprehensive Dentistry

Patient Registration and History

Date: ______________________

1. Patient Information

Name: ____
LAST FIRST MI

Preferred Name: ______________________________________

Gender: M/F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Birthdate: ____________ Age: _______ SSN: ______________

Mailing Address: ______________________________________

____
CITY STATE ZIP

E-Mail: ____

Home Phone: _______________ Work Phone: _____________

Cell Phone: ____

How did you hear about us? ____________________________

Employer: ____

Occupation: ____

Employer's Address: ___________________________________

____
CITY STATE ZIP

Spouse's Name: _______________________________________

Spouse's Employer: ____________________________________

Spouse's Work Phone: __________________________________

Who is responsible for this account? ____________________

Relationship to Patient: ________________________________

Emergency Contact: ____________________________________

Phone: ____

2. Insurance Information

Please give insurance card to the office on your first visit or if your insurance has changed.

PRIMARY DENTAL INSURANCE

Insurance Company: ____________________________________

Group #: ____

Primary Insurance Holder: _______________________________

SSN: ____________________ Birthdate: __________________

SECONDARY DENTAL INSURANCE

Insurance Company: ____________________________________

Group #: ____

Secondary Insurance Holder: _____________________________

SSN: ____________________ Birthdate: __________________

3. Medical History

Current or previous health problems as well as any medications you are taking could have an important interrelationship with the dental care you will receive. Thank you for answering the following questions.

Date of Last Medical Exam: ____________________________

Date of Last Dental Appt.: ____________________________

1. Y N Is your general health good? __________________
2. Y N Has your health changed within the last year? ______
3. Y N Have you ever been hospitalized or had a major operation? Please explain: ____________________
____
4. Y N Are you being treated by a physician now? For what?
____
5. Y N Have you had problems with prior dental treatment?
____
6. Y N Are you in pain now? _________________________
7. Y N Have you ever had a serious head or neck injury? _____
8. Y N Do you use tobacco? _________________________
9. Y N Do you use controlled substances or recreational drugs? Please list: __________________________
____
10. Y N Women, are you: ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Please continue on back

11. Y N **Are you currently taking or have you ever taken the following medication:** ☐ Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Pradaxa) ☐ Cialis, Viagra, Levitra ☐ Bone density medication or biophosphonates (Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Xgeva, Prolia, Reclast)

12. Y N **Are you currently taking any medication not mentioned above? Please list: (If you have a list, please hand it to the front desk to make a copy.)** ____________________

13. Y N **Are you allergic to or have you ever had a reaction to:** ☐ Penicillin ☐ Other antibiotics ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine or other narcotics ☐ Local anesthetic (numbing medicines) ☐ Other medications ☐ Latex

14. Y N **Do you have any allergies not mentioned above? Please list:** ____________________

15. Y N **Have you experienced any of the following? Check all that apply.**

☐ Heart Valve Replacement or Vascular Graft*
☐ Heart Surgery*
☐ Heart Attack(s)
☐ Heart Murmur
☐ Rheumatic or Scarlet Fever
☐ Irregular Heartbeat
☐ Cardiac Pacemaker
☐ Chest Pain/Angina
☐ Congestive Heart Failure
☐ High Blood Pressure
☐ Frequent Headaches
☐ Low Blood Pressure
☐ AIDS/HIV
☐ Cold Sores/Fever Blisters
☐ Pneumonia, Bronchitis, Chronic Cough
☐ Tuberculosis
☐ COPD
☐ Emphysema
☐ Asthma
☐ Anaphylaxis
☐ Difficult Breathing
☐ Hay Fever/Sinus Problems
☐ Seasonal Allergies
☐ Sleep Apnea/CPAP
☐ Smoke Cigarettes. Packs per day: __________
☐ Chewing Tobacco
☐ Blood Transfusion
☐ Blood Disorder/Anemia
☐ Bruise Easily
☐ Bleeding Tendency/ Abnormal Bleeding
☐ Hepatitis, Jaundice, or Liver Disease
☐ Convulsions/Epilepsy
☐ Fainting Spells
☐ Stroke
☐ Thyroid Trouble
☐ Diabetes
☐ Low Blood Sugar
☐ Kidney Trouble
☐ Dialysis therapy
☐ Swollen Ankles, Arthritis/ Joint Pain
☐ Prosthetic Joint/Implant*
☐ Osteoporosis/Osteopenia
☐ Osteonecrosis
☐ Back Surgery/Injury
☐ Stomach Ulcers/Acid Reflux
☐ Sexually Transmitted Diseases
☐ Cortisone Medicine
☐ Delay in Healing
☐ Tumor or Growth
☐ Cancer/Radiation Therapy/ Chemotherapy
☐ History of Alcohol Abuse
☐ History of Drug Abuse
☐ Stomach/Intestinal Disease
☐ Eye Disease/Glaucoma
☐ Mental Health Problems/ Anxiety/Depression
☐ Parkinson's
☐ Dry Mouth
☐ Alzheimer's/Dementia
☐ Frequent Diarrhea
☐ Jaw Pain or Clicking

*Condition may require medication before dental appointments

16. Y N **Have you ever had a serious illness not listed above? Please explain:** ____________________

Please Read and Sign Below

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

1. Payment for all services rendered is required at the time of each visit, unless other arrangements have been made with the office manager (i.e. estimate insurance payment). If account is not paid within 90 days of the date of service and no arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.
2. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
3. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ____________________ Date: ____________________

You are the: ☐ Patient ☐ Parent or Guardian