Patient Registration and Medical History

(Please Print) Cell Phone_____

Date_____ Home Phone_____

Patient_____
Last Name First Name Initial

Street Address_____City_____ St._____Zip_____

Sex: ☐ M ☐ F Age_____Birthdate_____Social Security #_____ ☐ Single ☐ Married ☐ Child

Employed by_____Occupation_____

Business Address_____Business Phone_____Ext._____

Spouse/Parent Name_____Spouse/Parent Birthdate_____Social Security #_____

Spouse/Parent Employed By_____Occupation_____Buisness Phone_____

Who is responsible for this account?_____Relationship to Patient ☐ Self ☐ Spouse ☐ Parent

In case of an emergency, who should be notified_____Phone #_____

Whom may we thank for referring you?_____

Medical History

Physician's Name_____Date of Last Physical_____

Have you ever had any of the following? (Check all that apply):

☐ Heart Problems	☐ Hepatitis, Jaundice, or Liver Disease	☐ "A.I.D.S" or Other Disorders
☐ High Blood Pressure	☐ Cancer	☐ Ulcer
☐ Low Blood Pressure	☐ Psychiatric Care	☐ Venereal Disease
☐ Circulatory Problems	☐ Chronic Diarrhea	☐ Chemical Dependency
☐ Nervous Problems	☐ Allergies to Anesthetics	☐ Hemophilia
☐ Radiation Treatment	☐ Allergies to Medicine or Drugs	☐ Artificial Joint*
☐ Artificial Heart Valves*	☐ General Allergies	☐ Chemotherapy
☐ Recent Weight Loss	☐ Blood Disease	☐ Heart Pace Maker*
☐ Back Problems	☐ Arthritis	☐ Kidney Problems
☐ Diabetes	☐ Special Diet	☐ Fainting or Dizziness
☐ Respiratory Disease	☐ Swollen Neck Glands	☐ Mitral Valve Prolapse*
☐ Epilepsy	☐ Rheumatic Fever*	☐ Asthma
☐ Headaches	☐ Sinus Problem	☐ Cold Sores

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____If so, what_____

_____

Are you taking any medications at this time? _____If so, what_____

_____

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions?_____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history?_____

(Over)

Dental History

What is the reason for your visit today?_____
_____

Date of Last Dental Visit_____Last Dental Cleaning_____Last Full Mouth X-Ray_____

How often do you brush your teeth? ☐ Less than once Daily ☐ Once Daily ☐ Twice Daily ☐ More than Twice Daily

How often do you floss? ☐ Daily ☐ Once a week ☐ More than once a week ☐ Once a month ☐ More than once a month

What type of Bristles do you use? ☐ Hard ☐ Medium ☐ Soft Your current dental health is ☐ Good ☐ Fair ☐ Poor

Are you satisfied with your teeth's appearance? ☐ Yes ☐ No Are you currently in pain? ☐ Yes ☐ No

Check all that apply:

Do You:

☐ Bite your lips or cheeks regularly
☐ Hold foreign objects with your teeth
☐ Have tired jaws, especially in the morning
☐ Mouth breath while asleep or awake
☐ Clench or grind your teeth while asleep or awake
☐ Smoke/Chew tobacco

Have you ever had:

☐ Gums to bleed or hurt
☐ Orthodontic treatment
☐ Oral surgery
☐ Periodontal treatment
☐ A serious injury to the mouth or head
☐ A change in your bite or loose teeth

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Date *Signature*

Financial Agreement

I acknowledge that payment is due at the time of treatment. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date *Signature*

I, _____ have insurance with_____and assign all benefits directly to Dr. Whitson.
Name of Insurance Company

_____ _____
Date *Signature*

Minor/Child Consent

I, being the parent or guardian of_____do hereby request and authorize the dental staff
Name of Minor/Child
to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.