DENTAL REGISTRATION AND HISTORY

Fairfax Complete Dental

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # (*optional*) _____

Patient Name _____

_____

Address _____

City _____

State _____ ZIP _____

Sex (*please circle*) Male Female

Date of Birth _____

Email _____

Employer _____

Please highlight or circle:

Married Widowed Single Minor

Separated Divorced Partnered for __ years

Spouse's Name _____

Employer _____

Date of Birth _____

SS# (*optional*) _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Company _____

Subscriber ID# _____

Group # _____

Is the patient covered by additional insurance? **Y** or **N**

Subscriber's Name _____

Date of Birth _____ SS# _____

Relationship to Patient _____

Insurance Company _____

Group # _____

ASSIGNMENT AND RELEASE

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

E-signature _____

PHONE NUMBERS

Phone (___)_____ Work (___)_____ Ext _____ Cell (___)_____

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 _____

Cell phone (___)_____ Work phone (___)_____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Circle "yes" or "no" if you have had any of the following:

Bad breath	YES	NO
Bleeding gums	YES	NO
Blisters on lips or mouth	YES	NO
Burning sensation on tongue	YES	NO
Chew on one side of mouth	YES	NO
Cigarette, pipe, cigar smoking	YES	NO
Clicking or popping jaw	YES	NO
Dry mouth	YES	NO
Fingernail biting	YES	NO
Food collection between the teeth	YES	NO
Foreign objects	YES	NO
Grinding teeth	YES	NO
Gums swollen or tender	YES	NO
Jaw pain or tiredness	YES	NO
Lip or cheek biting	YES	NO
Loose teeth or broken fillings	YES	NO
Mouth breathing	YES	NO
Mouth pain, brushing	YES	NO
Orthodontic treatment	YES	NO
Pain around ear	YES	NO
Periodontal treatment	YES	NO
Sensitivity to cold	YES	NO
Sensitivity to hot	YES	NO
Sensitivity to sweets	YES	NO
Sensitivity when biting	YES	NO
Sores or growths in your mouth	YES	NO

How often do you floss? _____

How often do you brush? _____