Virginia M. Mitchell, DDS | 631-615-4881 | 14 Market Street Centereach, NY 11720

# DENTAL REGISTRATION AND HISTORY

## PATIENT INFORMATION

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip

E-mail _____

Sex ☐M ☐F SS# _____

Patient's Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Domestic Partner

Patient Employer/School _____

Occupation _____

Whom may we thank for referring you?

_____

## SPOUSE

Spouse's Name _____

Birthdate _____

SS# _____

Spouse Employer

## DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance Co. _____

Group # _____

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependents(s), have insurance coverage with

_____and assign directly to
Name of insurance company(ies)

Virginia M. Mitchell, DDS, 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 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 of the benefits payable for related services.

_____
**Signature of Patient, Parent, Guardian or Personal Representative**

_____
**Please print name of Patient, Parent, Guardian or Personal Representative**

_____ _____
**Date** **Relationship to Patient**

## PHONE NUMBERS

Home ( ) _____ Work ( ) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____)_____Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT**

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 _____

Have you 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 |
| 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 heat | ☐ 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?_____

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

Do you wear contact lenses? ☐ Yes ☐ No

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 and the correlating diagnosis:

_____

_____

_____

Pharmacy Name: _____

Phone (_____)_____

## ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex _____

## (FOR DOCTOR'S USE ONLY )

## UPDATES

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?

Are you taking any new medications? _____ If so, what? _____

Patient Signature _____ Date _____

Doctor's Signature _____ Date _____