DYME DENTAL

Registration & History

Patient Information

Date_____ Occupation_____
Name_____ Patient Employer/School_____
Address_____ Employer/School Address_____
City_____ _____ _____
State_____ Zip_____ Employer/School Phone #_____
Home Phone #_____ Spouse Name_____
Cell Phone # _____ Birth date_____ S.S #_____
Email _____ Spouse Employer_____
Birth date_____ S.S# _____ Whom may we thank for referring you?_____

Check Appropriate Box: ☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Widowed

In case of emergency, who may we contact *(living in same home)* _____ Phone #_____

In case of emergency, who may we contact *(not living in same home)*_____ Phone #_____

Responsible Party

Name of Person Responsible for Account_____ Relationship to Patient _____
Birth date_____ S.S # _____
Address_____ Home Phone #_____
Email _____ Cell Phone #_____
Employer _____ Work Phone # _____

Insurance Information

Subscriber's Name_____ Is Patient Covered by Secondary Insurance? ☐ Yes ☐ No
Relationship to Patient_____ Subscriber's Name_____
Birth date_____ S.S. #_____ Relationship to Patient_____
Insurance Co. _____ Birth date_____ S.S. #_____
Policy/Member ID _____ Insurance Co._____
Group #_____ Phone #_____ Policy/Member ID_____
Name of Employer_____ Group #_____ Phone #_____
Name of Employer_____

Dental History

Please check any of the following problems that apply to you:

☐ Sensitivity (hot, cold, sweet) ☐ Loose, tipped or shifting teeth ☐ Grinding or clenching teeth
☐ Tooth pain or discomfort when chewing ☐ Bad breath or bad taste in your mouth ☐ Teeth or fillings breaking
☐ Headaches, earaches, neck pain ☐ Bleeding, swollen or irritated gums ☐ Jaw joint pain

On a scale of 1 – 5 with 5 the highest rating:

How important is your dental health to you? 1 2 3 4 5
Do you like your smile? 1 2 3 4 5
Do you want to keep your remaining teeth? 1 2 3 4 5
Do you feel nervous having dental treatment? 1 2 3 4 5

Name: _____ *Medical History*

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain:_____

Physician's Name: _____Phone:_____

Have you been hospitalized in the past 5 years? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Is premedication with antibiotics required before dental visits due to heart condition, artificial joint or other reason?

☐ Yes ☐ No If yes, please explain: _____

Have you ever taken medications for osteoporosis? *(i.e. Fosamax, Atelvia, Boniva, Actonel, Denosumab, Zometa, Prolia, Reclast)*

☐ Yes ☐ No If yes, please explain: _____

Are you taking any blood thinners? *(i.e. Coumadin, Warfarin, Apixaban, Eliquis, Plavix)* ☐ Yes ☐ No If yes, please list below under medications

Are you taking any medications, pills, prescriptions drugs or controlled substances? ☐ Yes ☐ No If yes, please list below under medications

Do you smoke or use chewing tobacco? ☐ Yes ☐ No How many/day? _____ Years? _____

Women: Are you ☐ Pregnant ☐ Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives? *(list medication below)*

MEDICATION	Dose	Frequency	MEDICATION	Dose	Frequency

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Latex ☐ Metal ☐ Local Anesthetics

☐ Sulfa Drugs ☐ Other *(Please specify)* _____

Do you have, or have you ever had, any of the following?

☐ AIDS/HIV Positive	☐ Blood Transfusion	☐ Diabetes	☐ Heart Disease	☐ Low Blood Pressure	☐ Stomach/Intestinal Disease
☐ Alzheimer's Disease	☐ Breathing Problems /Shortness of Breath.	☐ Drug Addiction	☐ Hemophilia	☐ Lung Disease	☐ Spina Bifida
☐ Anaphylaxis	☐ Bruise Easily	☐ Emphysema/Bronchitis	☐ Hepatitis A	☐ Mitral Valve Prolapse	☐ Stroke
☐ Anemia	☐ Cancer	☐ Epilepsy/Seizures	☐ Hepatitis B or C	☐ Psychiatric Care	☐ Thyroid Disease
☐ Angina	☐ Chemotherapy	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Radiation Treatment	☐ Tonsillitis
☐ Anorexia/Bulimia	☐ Chest Pains	☐ Fainting/Dizziness	☐ Hypoglycemia	☐ Renal Dialysis	☐ Tuberculosis
☐ Arthritis/Gout	☐ Cold Sores/Fever Blisters	☐ Gerd	☐ Infective Endocarditis	☐ Rheumatism	☐ Tumor/Growths
☐ Artificial Heart Valve	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Irregular Heartbeat	☐ Scarlet Fever	☐ Ulcers
☐ Artificial Joint	☐ Convulsions	☐ Heart Attack/Failure	☐ Kidney Problems	☐ Shingles	☐ Venereal Disease
☐ Asthma	☐ Cortisone Medicine	☐ Heart Murmur	☐ Leukemia	☐ Sickle Cell Disease	☐ Osteoporosis
☐ Blood Disease		☐ Heart Pacemaker	☐ Liver Disease	☐ Sinus Trouble	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please specify _____

Comments: _____

_____

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners.

Signature of Patient, Parent/Guardian _____ Date _____

Relationship to Patient _____Signature of Dentist Reviewing _____