



### Patient Information

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_



### Dental Insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

#### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Jayashree Srinivasan 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_



### Phone Numbers

Home \_\_\_\_\_ Work \_\_\_\_\_ Ext \_\_\_\_\_ 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 \_\_\_\_\_

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 \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate 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, or 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 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? \_\_\_\_\_



## Dental Registration and History





# Health History

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

|   |  |                             |  |                                    |  |
|---|--|-----------------------------|--|------------------------------------|--|
| AIDS  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis<br>Type _____     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with<br>extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer  | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV Positive                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Feet or<br>Ankles      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or<br>bloody                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on<br>head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you wear<br>contact lenses?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Women:<br>Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss,<br>unexplained        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  | Due date _____              |  |                                    |  |
|   |  | Are you nursing?            | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                    |  |



## Medications

List medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone \_\_\_\_\_



## Allergies

|  |   |
|--|---|
| <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin       |
| <input type="checkbox"/> Codeine                       | <input type="checkbox"/> Sulfa            |
| <input type="checkbox"/> Iodine                        | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Latex                         | _____                                     |



## Updates (To be filled in at future appointments)

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's 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's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_