

## REGISTRATION FORM

Name (first) \_\_\_\_\_ (middle initial) \_\_\_\_\_ (last) \_\_\_\_\_

Address \_\_\_\_\_

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

Occupation \_\_\_\_\_ Social Security# \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

(pager) \_\_\_\_\_ (cell) \_\_\_\_\_ (e-mail) \_\_\_\_\_

Single  Married  Widowed  Divorced

Employed By \_\_\_\_\_

If Self-Employed, Name of Business/Address \_\_\_\_\_

Employer's Address \_\_\_\_\_

How did you learn about our office? \_\_\_\_\_

Hobbies/Interests \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_

Occupation of Spouse \_\_\_\_\_ Spouse's Work Phone \_\_\_\_\_

Spouse's Birthdate \_\_\_\_\_ Name of Spouse's Employer \_\_\_\_\_

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

Person to notify in an emergency (not at home address) \_\_\_\_\_ Phone \_\_\_\_\_

### **Dental Insurance Information**

Insured is  Self  Husband  Wife  Mother  Father

Employee's Name \_\_\_\_\_ Employee's Social Security # \_\_\_\_\_

Employee's Date of Birth \_\_\_\_\_ Contract ID # \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Are you covered by a second insurance company?  Yes  No

If yes, name of 2nd insurance co. \_\_\_\_\_ Group # \_\_\_\_\_

Employee Name for 2nd ins. \_\_\_\_\_ SSN for 2nd ins. \_\_\_\_\_

Employee Birthdate for 2nd ins. co. \_\_\_\_\_ Contract ID # \_\_\_\_\_

### **Must Complete if Under 18 or Full-time Student/Responsibility Party Information Required**

Mother's Name \_\_\_\_\_ Mother's Social Security # \_\_\_\_\_

Mother's Address \_\_\_\_\_

Mother's Home Phone # \_\_\_\_\_ Birthdate \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Father's Social Security # \_\_\_\_\_

Father's Address \_\_\_\_\_

Father's Home Phone # \_\_\_\_\_ Birthdate \_\_\_\_\_

Father's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

**Please turn the page!**

Patient's name: \_\_\_\_\_

I understand that as a service to me, Porph & Yokley, D.M.D., P.C. will assist me in processing my insurance claims. However, I am completely responsible for all fees in their entirety. This office quotes current fees that are within the usual and customary range of dental services in our area, while many insurance companies pay from a set fee schedule. I understand that Porph & Yokley, D.M.D., P.C. is required by law to maintain the privacy of my protected health information and to provide me with notice of their legal duties and privacy practices with respect to protected health information.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signed (patient or parent if minor)

Please list the name (and relationship to you) of any person(s) with whom we can discuss your dental condition/diagnosis:

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

***Only if you have insurance:***

So that you don't have to sign an insurance form at each dental visit, Porph & Yokley, D.M.D., P.C. will maintain this "signature on file" for you.

**Authorization to Release Information:** I hereby authorize any Provider, insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signed (patient or parent if minor)

**Authorization to Pay Benefits to below named Dentist:** Where applicable, I hereby authorize payment to Porph & Yokley, D.M.D., P.C. for services rendered.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signed (patient or parent if minor)

<b>Patient Name</b>
<b>Patient Account No.</b>

# DENTAL HISTORY

<b>Medical Alert</b>
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*Welcome! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? \_\_\_\_\_  
 \_\_\_\_\_

**Date of Last Dental Visit** \_\_\_\_\_ **Last Dental Cleaning** \_\_\_\_\_ **Last Full Mouth X-Rays** \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_  
 \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_  
 Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone \_\_\_\_\_

**How often do you have dental examinations?** \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_  
 What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

**Do you have any dental problems now?** Yes No

If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

**Do your gums bleed or hurt?** Yes No

Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? \_\_\_\_\_

**Do you:**

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/Chew tobacco?	Yes	No

**Have you ever had:**

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause: \_\_\_\_\_  
 \_\_\_\_\_

**Have you experienced:**

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

**Are you satisfied with your teeth's appearance?** Yes No

Would you like to keep all of your teeth all your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern? \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had an upsetting dental experience? Yes No  
 If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

**Is there anything else about having dental treatment that you would like us to know?** Yes No

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

# MEDICAL HISTORY

Patient Name _____
Patient Account No. _____

Medical Alert _____
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1. Have you been under the care of a medical doctor during the past two years? ..... Yes No  
 If yes, for what? \_\_\_\_\_  
 Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs or pills now? ..... Yes No  
 If yes, please list name and dosage: \_\_\_\_\_
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? ..... Yes No  
 If yes, please list: \_\_\_\_\_
5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item:
 

Heart (Surgery, Disease, Attack).....	Yes	No	Ulcers.....	Yes	No	Hepatitis A (infectious) B (serum).....	Yes	No
Chest Pain.....	Yes	No	Diabetes.....	Yes	No	Venereal Disease.....	Yes	No
Congenital Heart Disease.....	Yes	No	Thyroid Problems.....	Yes	No	A.I.D.S.....	Yes	No
Heart Murmur.....	Yes	No	Glaucoma.....	Yes	No	H.I.V. Positive.....	Yes	No
High Blood Pressure.....	Yes	No	Contact lenses.....	Yes	No	Cold Sores/Fever Blisters.....	Yes	No
Mitral Valve Prolapse.....	Yes	No	Emphysema.....	Yes	No	Blood Transfusion.....	Yes	No
Artificial Heart Valve.....	Yes	No	Chronic cough.....	Yes	No	Hemophilia.....	Yes	No
Heart Pacemaker.....	Yes	No	Tuberculosis.....	Yes	No	Sickle Cell Disease.....	Yes	No
Rheumatic Fever.....	Yes	No	Asthma.....	Yes	No	Bruise Easily.....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Hay Fever.....	Yes	No	Liver Disease.....	Yes	No
Cortisone Medicine.....	Yes	No	Latex Sensitivity.....	Yes	No	Yellow Jaundice.....	Yes	No
Swollen Ankles.....	Yes	No	Allergies or Hives.....	Yes	No	Neurological Disorders.....	Yes	No
Stroke.....	Yes	No	Sinus Trouble.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Diet (Special/Restricted).....	Yes	No	Radiation Therapy.....	Yes	No	Fainting or Dizzy Spells.....	Yes	No
Artificial Joints (hip, knee, etc.).....	Yes	No	Chemotherapy.....	Yes	No	Nervous/Anxious.....	Yes	No
Kidney Trouble.....	Yes	No	Tumors.....	Yes	No	Psychiatric/Psychological Care.....	Yes	No
7. Do you use more than two pillows to sleep? ..... Yes No
8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No  
 If yes, please list: \_\_\_\_\_
10. Women. Are You: **Pregnant?** Yes, \_\_\_ Months No      **Nursing?** Yes No      **Taking birth control pills?** Yes No

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.*

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## History Review

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_