DENTAL REGISTRATION AND MEDICAL HISTORY

Patient Information:

Date: ____________

Patient Name: ____
Last Name First Name Middle Initial Preferred First Name

Address: ____

City: ______________________ State: ________ Zip: ______________

Sex: ☐ Male ☐ Female Age: ________ Birthdate: ______________ SS#: ______________
☐ Married ☐ Single ☐ Separated ☐ Child ☐ Other

Patient Employer/School: ______________________ Occupation: ______________________
Employer/School Address: ______________________
Employer/School Phone: ______________________
Spouse's Name: ______________________ Spouse's Birthdate: ______________
Spouse's Employer: ____

Who is responsible for this account? ______________________ Relationship: ____________
Whom may we thank for referring you? ____

Phone Numbers:

Home: ______________ Work: ______________ Ext: ______ Cell Phone: ______________
Spouse's Work: ______________ Email: ______________________________

In case of Emergency, Contact (specify someone who does not live in your household)
Name: ______________________________ Relationship: ______________
Home: ______________ Work: ______________ Ext: ______ Cell Phone: ______________

Dental Insurance:

Primary Insurance Co: ______________________ Phone: ______________
Primary Subscriber's Name: ______________________ Group #: ______________
Primary Subscriber's SS#/ID: ______________________ Birthdate: ______________

Secondary Insurance Co: ______________________ Phone: ______________
Secondary Subscriber's Name: ______________________ Group #: ______________
Secondary Subscriber's SS#/ID: ______________________ Birthdate: ______________

Assignment and Release
I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Sebastian Castellano 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 of my signature on all insurance submissions.

The above name 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 payments for services and determining insurance benefits or the benefits payable for related services.

____ ______________
Signature Date

____ ______________
Printed Name of Patient, Parent, Guardian, or Personal Representative Relationship to patient

Medical History:

Place a mark to indicate if you have had any of the following:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type ___________
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, unexplained
- ☐ Eating Disorders
- ☐ Other ____________________

Women: Are you pregnant? ☐ Yes ☐ No Due Date: ________________ Are you nursing? ☐ Yes ☐ No
Taking birth control pills? ☐ Yes ☐ No

Physician's Name: ____ Date of last visit: ___________________________

Medications:

List any medications you are currently taking and the correlating diagnosis: ____

____

____

Pharmacy/Phone: ____

Allergies:

Do you have any drug allergies or have you ever had an adverse reaction to any medication? ☐ Yes ☐ No If so, what __________

____

____

Dental History:

Place a mark to indicate if you have had any of the following:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Foreign objects
- ☐ Grinding teeth/clinching
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment/cleaning
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity to biting
- ☐ Sores or growths in your mouth
- ☐ Thumb sucking

Tobacco Use: ☐ Yes ☐ No If so, frequency: ____
How often do you floss? ____________________ How often do you brush? ______________

All information (front and back of this form) is accurate and complete to the best of my knowledge and is for use in my treatment, billing, and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in completion of this form.

____ _________________________

Signature **Date**