SPENCER FAMILY DENTAL

Patient Registration and History

Please take a few minutes to complete this form so we can best serve you...

Patient Information

Date____________________ SS#_____________________

Patient Name____

Preferred Name____

Home Phone__________________Cell____________________

Address____

City__________________________ State______Zip__________

Email____

Sex ☐M ☐F Birthdate________________

Employer____________________ Work Phone #____________

Emergency Contact Name_____________________________

Emergency Contact Phone #___________________________

Physician's Name_______________________________________

Last Visit to Physician____________________

Last Dental Visit________________________

How did you hear about our office?_________________________

Dental Insurance

Primary Dental Insurance___________________________________

Subscriber______________________________

Birthdate___________________ SS#_________________________

Relationship to Patient_____________________________________

Group #____________________ Ins. Phone #_________________

Secondary Dental Insurance_________________________________

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage as noted above, and assign directly to Drs' Spencer 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 my 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 or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient/Guardian Signature:___________________________

Date:___________________________

Dental Health History

Please complete to the best of your knowledge:

	Yes	No
Do you want complete dental care?	☐	☐
Are you apprehensive about dental treatment?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you have difficulty chewing?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Do your gums bleed when you brush or floss?	☐	☐

	Yes	No
Does your mouth feel dry often?	☐	☐
Have you noticed slow-healing sores in your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Hot foods or liquid?	☐	☐
Cold foods or liquid?	☐	☐
Sweets?	☐	☐
Biting?	☐	☐
Does your jaw make noise that bothers you or others?	☐	☐
Do you clench or grind your teeth frequently?	☐	☐
Do you have any jaw symptoms or headaches upon awakening in the morning?	☐	☐
Do you experience jaw or ear pain?	☐	☐

Medical Health History

Name________________________________ Date__________________

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

Condition	Yes	No
AIDS/HIV	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial Heart Valves	☐	☐
Artificial Joints, Location_____________	☐	☐
Asthma	☐	☐
Back Problems	☐	☐
Bleeding Problems/Easy Bruising	☐	☐
Blood Disease	☐	☐
Cancer, Type_____________________	☐	☐
Chemical/Alcohol Dependency	☐	☐
Chemotherapy	☐	☐
Circulatory Problems	☐	☐
Congenital Heart Problems	☐	☐
Cortisone Treatments	☐	☐
Cough, persistent or bloody	☐	☐
Depression/Anxiety	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting/Dizziness	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Head Injury	☐	☐
Heart Murmur	☐	☐
Heart Problems	☐	☐
Hepatitis Type_________	☐	☐
Herpes or other STD	☐	☐
High Blood Pressure	☐	☐
Jaundice	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Mitral Valve Prolapse	☐	☐
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/neck	☐	☐
Ulcer	☐	☐
Weight loss, unexplained	☐	☐

____

Other Condition or Disease not listed above

Women:

	Yes	No
Are you pregnant?	☐	☐
expected delivery date____________		
Taking contraceptives or other hormones?	☐	☐

Medications

List all medications you are currently taking:

____

____

____

____

____

____

Airway Health

	Yes	No
Do you feel excessively tired throughout the day?	☐	☐
Do you wish you slept better and had more energy?	☐	☐
Have you ever been told you occasionally snore?	☐	☐
Have you or a loved one been prescribed a C-PAP?	☐	☐

Allergies

	Yes	No
Local anesthetics (“Novocaine”)	☐	☐
Penicillin	☐	☐
Sulfa	☐	☐
Valium or other sleeping pills	☐	☐
Aspirin	☐	☐
Tylenol	☐	☐
Ibuprofen	☐	☐
Codeine or other narcotics	☐	☐
Latex	☐	☐
Metals	☐	☐

Other____________________________________

Consent:

I hereby agree to allow Dr. Spencer and associates to perform any necessary, agreed upon dental services. I also allow them to delegate to the auxiliaries of their choice as needed to accomplish my treatment. I understand that there is inherent risk with any dental procedure, including dental anesthesia. I hereby allow them to take any necessary x-rays, study models or photographs as needed for my dental care. I understand that the entire fee is my responsibility and that Dr. Spencer’s office will submit to my dental insurance as a courtesy. I agree to be responsible for any collection fees necessary to pursue a past debt.

Patient/Guardian Signature:__________________________ **Dentist Signature:**__________________________________