Patient Name: _____ Birthdate: _____

DENTAL REGISTRATION AND HISTORY

Today's Date: _____

PATIENT INFORMATION

Name _____ _____ _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex **M** ☒ **F** ☐ Single ☐ Married ☐ Widowed ☐
Age: _____ Birthdate: mm/dd/yyyy Separated ☐ Divorced ☐

Home Phone: _____ Cell Phone: _____

eMail Address: _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? Phone 1: _____

Name: _____ Phone 2: _____

PRIMARY INSURANCE

Person Responsible for Account: _____ _____ _____
Last Name First Name Initial

Relationship to Patient: _____ Birthdate: mm/dd/yyyy Soc. Sec. # _____

Address (If different from patient's) Phone 1: _____

Phone 2: _____

City _____ State _____ Zip _____

Person Responsible Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____ Contact Number: _____

Group Number: _____ Subscriber Number: _____

Patient Name: _____ Birthdate: _____

ADDITIONAL INSURANCE

Is this patient covered by additional insurance? **Yes** ☐ **No** ☐ (If no, skip the rest of this section)

Subscriber Name: _____ (Last Name) _____ (First Name) _____ (Initial)

Relationship to Patient: _____ Birthdate: _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone 1: _____

Phone 2: _____

City _____ State _____ Zip _____

Subscriber Employed By: _____ Business Phone: _____

Insurance Company: _____

Contact Number: _____ Group Number: _____ Subscriber Number: _____

Names of other dependents covered under this plan: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with

_____

(name of insurance company)

and assign directly to Dr. J. T. Bae & Associates 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 user of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

I understand that J.T. BAE, D.D.S. & ASSOCIATES dba FAMILY DENTISTRY reserves the right to charge a fee for any appointment missed or canceled less than forty-eight (48) hours in advance. I also understand that after three (3) missed appointments in a twelve (12) month period, course of treatment with this office may be discontinued.

Initials: _____

Patient Name: _____ Birthdate: _____

PATIENT DENTAL HISTORY

Reason for Today's visit:

Previous Dentist: _____ Address or Phone: _____

Reason for leaving your previous dentist:

Please provide the approximate dates below for…

Last Dental Visit	Last Dental Exam	Last Full X-Rays	Last Cleaning

Have you ever had any serious problems with past dental treatment? **Yes** ☐ **No** ☐
If Yes, please explain:

Do you have or have you ever been treated for:	**Yes**	**No**
Bad Breath?	☐	☐
Bleeding Gums when Brushing/Flossing?	☐	☐
Periodontal Treatment?	☐	☐
Clicking or Popping Jaw?	☐	☐
Grinding Teeth (Headaches)?	☐	☐
Pain, Soreness of Facial Muscles?	☐	☐
Food Collecting Between Teeth?	☐	☐
Loose Teeth or Broken Fillings?	☐	☐
Sensitivity to Cold?	☐	☐
Sensitivity to Hot?	☐	☐
Sensitivity to Sweets?	☐	☐
Sensitivity to Biting?	☐	☐
Sores or Growths in Your Mouth?	☐	☐
Do you have dental implants?	☐	☐
Are you happy with your smile?	☐	☐

PATIENT MEDICAL HISTORY

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all of the questions in detail. Remember to include all information even if you do not think it to be important.

Do you have or have you ever been treated for:	**Yes**	**No**	**Do you have or have you ever been treated for:**	**Yes**	**No**
Heart Failure	☐	☐	Low Blood Pressure	☐	☐
Heart Disease	☐	☐	History of Fainting	☐	☐
Heart Attack	☐	☐	Rheumatic Fever	☐	☐
Heart Murmur*	☐	☐	Congenital Heart Lesions*	☐	☐
Mitral Valve Prolapse	☐	☐	Scarlet Fever	☐	☐
High Blood Pressure	☐	☐	Artificial Heart Valve	☐	☐

Patient Name: _____ Birthdate: _____

Do you have or have you ever been treated for:	Yes	No
Heart Pacemaker	☐	☐
Heart Surgery	☐	☐
Artificial Joint	☐	☐
Anemia	☐	☐
Hemophilia	☐	☐
Bleeding Disorders	☐	☐
Sickle Cell Trait	☐	☐
Blood Transfusion	☐	☐
Do You Smoke	☐	☐
Emphysema	☐	☐
Cough	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Asthma	☐	☐
Hayfever	☐	☐
Sinus Trouble	☐	☐
Allergies or Hives	☐	☐
Diabetes	☐	☐
Thyroid Disease	☐	☐
Adrenal/Pituitary Problems	☐	☐
X-Ray or Cobalt Treatment	☐	☐
Chemotherapy	☐	☐
Cancer or Leukemia	☐	☐
Arthritis	☐	☐
Rheumatism	☐	☐
Glaucoma	☐	☐
HIV/AIDS	☐	☐
Hepatitis A (Infectious)	☐	☐
Hepatitis B (Serum)	☐	☐
Hepatitis C	☐	☐
Hepatitis-Other	☐	☐
Liver Disease	☐	☐
Yellow Jaundice	☐	☐
Drug Addiction	☐	☐
Psychiatric Treatment	☐	☐
Phen/Fen Regimen	☐	☐
Alcohol Addiction	☐	☐
Sexually Transmitted Disease	☐	☐
Epilepsy or Seizures	☐	☐
Nervousness	☐	☐

*** Do you need to take antibiotic pre-medication prior to dental treatment?**

Yes ☐ No ☐

If Yes, please list the name of the antibiotic:

Allergic reaction (hives or swelling) to:	Yes	No
Acrylic	☐	☐
Penicillin	☐	☐
Erythromycin	☐	☐
Sulfa	☐	☐
Codeine	☐	☐
Aspirin	☐	☐
Local Anesthetic (Novocaine)	☐	☐
Latex	☐	☐
Other (i.e., fruits, nuts)	☐	☐

If you are a female, are you:	Yes	No
Pregnant	☐	☐
Nursing	☐	☐
Taking Birth Control	☐	☐
Taking Hormone Medications	☐	☐

WARNING: Antibiotics reduce the effects of birth control pills.

Please provide the following information regarding your OB/GYN:

Name: _____

Address: _____

Phone: _____

Patient Name: _____ Birthdate: _____

Other Conditions Not Listed Here:

If you are currently being treated by a physician, please explain why:

Date of last medical exam: mm/dd/yyyy

Physician Information:

Name:

Address:

Phone:

Please list any medications, pills, or tonics currently being taken:

Item:		Taken For:	
Item:		Taken For:	
Item:		Taken For:	
Item:		Taken For:	
Item:		Taken For:	
Item:		Taken For:	
Item:		Taken For:	
Item:		Taken For:	

SIGNATURE

I have provided accurate information to the best of my knowledge related to my medical and dental health. I understand that I am responsible to inform the office of any changes in health history.

Patient Signature: _____ Date: mm/dd/yyyy

(If minor, parent or guardian signature)

Dentist: _____ Date: _____

Patient Name: ____________________ Birthdate: __________

MEDICAL HISTORY REVIEW AND UPDATE	
Date: **Changed** ☐ **No Change** ☐	
List Changes	**New Medications**
Patient Signature:	
Dentist/Hygienist Signature:	

MEDICAL HISTORY REVIEW AND UPDATE	
Date: **Changed** ☐ **No Change** ☐	
List Changes	**New Medications**
Patient Signature:	
Dentist/Hygienist Signature:	

MEDICAL HISTORY REVIEW AND UPDATE	
Date: **Changed** ☐ **No Change** ☐	
List Changes	**New Medications**
Patient Signature:	
Dentist/Hygienist Signature:	