DENTAL REGISTRATION AND HISTORY

SHAWN E. REESE, DDS, MS, PC
526 BLUEGRASS COURT
CEDAR FALLS, IOWA 50613
(319) 266-3393

Email Address _____
Cell Phone _____
Home Phone _____

Date _____

PATIENT INFORMATION

Name _____ Social Security # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex: ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

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

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Social Security # _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of others dependents covered by this plan _____

SECONDARY DENTAL INSURANCE

Its patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Occupation _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of others dependents covered by this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assigned directly to Dr. Reese all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I'm 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 benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

OVER

DENTAL HISTORY

Reason for today's visit_____

_____

_____

General Dentist _____

City/State_____

Date of last dental visit _____

Date of last dental X-rays_____

Do you have any of the following:

☐ Bad breath

☐ Bleeding gums

☐ Blisters on lips or mouth

☐ Burning sensation on tongue

☐ Chew on one side of mouth

☐ Cigarette, pipe, or cigar smoking

_____ packs/day _____ # yrs.smoking

☐ Clicking or popping jaw

☐ Dry mouth

☐ Fingernail biting

☐ Food collection between the teeth

☐ Foreign objects

☐ Grinding teeth

☐ 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

☐ Sensitivity to cold

☐ Sensitivity to heat

☐ Sensitivity to sweets

☐ Sensitivity when biting

☐ Sores or growths in your mouth

How often do you floss?_____

How often do you brush?_____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. If you answer yes, please list on line.

Are you under a physician's care now? ○ Yes ○ No ○ N/A _____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No ○ N/A _____

Have you ever had a serious head or neck injury? ○ Yes ○ No ○ N/A _____

Are you taking any medications, pills, or drugs? ○ Yes ○ No ○ N/A _____

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No ○ N/A _____ Do you use tobacco? ○ Yes ○ No ○ N/A

Are you on a special diet? ○ Yes ○ No ○ N/A Do you use controlled substances? ○ Yes ○ No ○ N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives? _____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other_____

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

☐ AIDS/HIV Positive	☐ Cold Sores/Fever Blisters	☐ Glaucoma	☐ Liver Disease	☐ Spina Bifida
☐ Alzheimer's Disease	☐ Congenital Heart Disorder	☐ Hay Fever	☐ Low Blood Pressure	☐ Stomach/Intestinal Disease
☐ Anaphylaxis	☐ Convulsions	☐ Heart Attack/Failure	☐ Lung Disease	☐ Stroke
☐ Anemia	☐ Cortisone Medicine	☐ Heart Murmur*	☐ Mitral Valve Prolapse*	☐ Swelling of Limbs
☐ Angina	☐ Diabetes	☐ Heart Pace Maker*	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Arthritis/Gout	☐ Drug Addiction	☐ Heart Trouble/Disease	☐ Parathyroid Disease	☐ Tonsillitis
☐ Artificial Heart Valve*	☐ Easily Winded	☐ Hemophilia	☐ Psychiatric Care	☐ Tuberculosis
☐ Artificial Joint*	☐ Emphysema	☐ Hepatitis A	☐ Radiation Treatments	☐ Tumors or Growths
☐ Asthma	☐ Epilepsy or Seizures	☐ Hepatitis B or C	☐ Recent Weight Loss	☐ Ulcers
☐ Blood Disease	☐ Excessive Bleeding	☐ Herpes	☐ Renal Dialysis	☐ Venereal Disease
☐ Blood Transfusion	☐ Excessive Thirst	☐ High Blood Pressure	☐ Rheumatic Fever*	☐ Yellow Jaundice
☐ Breathing Problem	☐ Fainting Spells/Dizziness	☐ Hives or Rash	☐ Rheumatism	
☐ Bruise Easily	☐ Frequent Cough	☐ Hypoglycemia	☐ Scarlet Fever	
☐ Cancer	☐ Frequent Diarrhea	☐ Irregular Heartbeat	☐ Shingles	
☐ Chemotherapy	☐ Frequent Headaches	☐ Kidney Problems	☐ Sickle Cell Disease	
☐ Chest Pains	☐ Genital Herpes	☐ Leukemia	☐ Sinus Trouble	

Have you ever had any serious illness not listed above? ○ Yes ○ No ○ N/A _____

Have you ever had either of the following chemotherapy treatments? ○ Zoledronic Acid/Zometa ○ Pamidronate Disodium/ Aredia ○ N/A

Comments:_____

*Condition may require medication N/A-Not answered by patient

SIGNATURE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN DATE