SAN ANTONIO
PERIODONTICS & IMPLANTS
4501 McCullough Ste 104, San Antonio, TX 78212
Tel: 210.824.0111 **www.sanantonioperioandimplant.com**

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

Name (Last, First, Middle) _____

Address _____ City _____ State _____ Zip _____

E-mail _____ Sex ☐M ☐F Age _____ Birthdate _____

☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for ___ years

DENTAL INSURANCE

Who is responsible for this account? _____ Relationship to Patient _____

Insurance Co. _____ Group # _____ Is patient covered by additional insurance? ☐Y ☐N

Subscriber's Name _____ Birthdate _____ SS# _____

Relationship to Patient _____ Insurance Co. _____ Group # _____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all 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.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____

Print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

PHONE NUMBERS

Phone _____ Work _____ Ext. _____ Cell _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐Yes	☐No
Bleeding gums	☐Yes	☐No
Blisters on lips or mouth	☐Yes	☐No
Burning sensation on tongue	☐Yes	☐No
Chew on one side of mouth	☐Yes	☐No
Cigarette, pipe, or cigar smoking	☐Yes	☐No
Clicking or popping jaw	☐Yes	☐No
Dry mouth	☐Yes	☐No
Fingernail biting	☐Yes	☐No
Food collection between teeth	☐Yes	☐No
Foreign objects	☐Yes	☐No
Grinding teeth	☐Yes	☐No
Jaw pain or tiredness	☐Yes	☐No
Lip or cheek biting	☐Yes	☐No
Loose teeth or broken fillings	☐Yes	☐No
Mouth breathing	☐Yes	☐No
Mouth pain, brushing	☐Yes	☐No
Orthodontic treatment	☐Yes	☐No
Pain around ear	☐Yes	☐No
Peridontal treatment	☐Yes	☐No
Sensitivity to cold	☐Yes	☐No
Sensitivity to heat	☐Yes	☐No
Sensitivity to sweets	☐Yes	☐No
Sensitivity when biting	☐Yes	☐No
Sores or growths in your mouth	☐Yes	☐No

How often do you floss? _____

How often do you brush? _____

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DENTAL REGISTRATION AND HISTORY

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine, Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Do you wear contact lenses?	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Fainting or Dizziness	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
		Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

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

_____

_____

Pharmacy Name _____

Phone _____

Address _____

_____

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____

_____

SIGNATURE

_____

Signature

_____

Date