PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ ext_____

Cell Phone: ( ) _____ Pager: ( ) _____

Birth Date: _____ Soc. Sec. #: _____ Drivers License #: _____

Employer/Occupation: _____

Patient Information

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ ext _____

Cell Phone: ( ) _____

Sex: ○ Male ○ Female

Birth Date: _____ Age: _____

Soc. Sec. #: _____ Drivers License #: _____

Employment Status: ○ Full Time ○ Part Time ○ Retired

Employer/Occupation: _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Spouse's Name: _____

Spouse's Employer/Occupation: _____ Work Phone: ( ) _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec. #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip _____ City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec. #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

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

Signature of Patient, Parent, Guardian or Personal Representative: _____

Please Print Above Signature: _____ Date: _____ Relationship to Patient: _____

- O V E R –

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

How often do you floss? _____

How often do you brush? _____

Additional Information

Emergency Contact:

Name: _____ Relationship to Patient: _____

Address: _____ City, State, Zip: _____

Phone Numbers - Home: ( ) _____ Work: ( ) _____

Preferred Pharmacy: _____ City: _____

How did you hear about our office?

☐ Newspaper Ad

☐ Telephone Book

☐ Mailout Brochure

☐ Referral from Friend/Family Member

Please fill out the medical history on the following page.

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.

Patient Name: _____

Primary Physician's Name: _____

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

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

☐ Other, please explain: _____

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

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medications ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Breathing Problem ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pace Maker ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No	☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Comments: _____

_____

_____

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 _____

Medical History Form