**DENTAL**

**REGISTRATION**

**AND HISTORY**

(PLEASE PRINT)

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3610 2nd Avenue

Kearney, NE 68847 (308) 237-1311

Date  Home Phone Cell Phone 

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| **PATIENT INFORMATION**  |

Name  SS/HIC/Patient ID # 

Last Name First Name Middle Initial

Address E-mail

City State Zip 

Sex ⬜M ⬜F AgeBirthdate ⬜Married ⬜Separated ⬜Minor ⬜Widowed

 ⬜Divorced ⬜Single ⬜Partnered foryears

Patient Employer/School Occupation

Employer/School Address  Employer/School Phone

Whom should we thank for referring you? 

In case of emergency who should be notified? Phone 

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| **PRIMARY INSURANCE** |

Person Responsible for Account 

 Last Name First Name Middle Initial

Relation to Patient  Birthdate  Soc. Sec. # 

Address (If different from patient's)  Phone 

City  State Zip  Person Responsible Employed by Occupation 

Business Address Business Phone

Insurance Company 

Contract #Group # Subscriber #

Names of other dependents covered under this plan 

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| **ADDITIONAL INSURANCE**  |

Is the patient covered by additional insurance? ⬜ Yes ⬜ No

Subscriber Name  BirthdateRelation to Patient 

Address (If different from patient's) Phone 

City State Zip 

Subscriber Employed by Business Phone 

Insurance Company  Soc. Sec. #

Contract #Group # Subscriber #

Names of other dependents covered under this plan 

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| **ASSIGNMENT AND RELEASE**  |

I certify that I, and/or my dependent(s), have insurance coverage with  and assign directly to Dr.  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 doctor 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 Date

 

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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**DENTAL HEALTH HISTORY**

**(Confidential)**

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| **DENTAL HISTORY**  |

Reason for Today's Visit Date of last dental care 

Former Dentist Date of last dental X-rays. 

Address

Check (✓) if you have had problems with any of the following:

⬜ Bad breath ⬜Grinding teeth ⬜Sensitivity to hot

⬜Bleeding gums ⬜Loose teeth or broken fillings ⬜Sensitivity to sweets

⬜Clicking or popping jaw ⬜Periodontal treatment ⬜Sensitivity when biting

⬜Food collection between teeth ⬜Sensitivity to cold ⬜Sores or growths in your mouth

How often do you floss? How often do you brush? 

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| **MEDICAL HISTORY**  |

Physician's Name  Date of Last Visit 

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. h Yes h No Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ⬜ Yes ⬜ No

Have you had any serious illnesses or operations? If yes, describe 

Have you ever had a blood transfusion? ⬜ Yes ⬜ No If yes, give approximate dates

(Women) Are you pregnant? ⬜ Yes ⬜ No Nursing? ⬜ Yes ⬜ No Taking birth control pills? ⬜ Yes ⬜ No

Check () if you have or have had any of the following:

⬜Anemia ⬜Cortisone Treatments ⬜Hepatitis ⬜Scarlet Fever

⬜Arthritis, Rheumatism ⬜Cough, Persistent ⬜High Blood Pressure ⬜Shortness of Breath

⬜Artificial Heart Valves ⬜Cough up Blood ⬜HIV/AIDS ⬜Skin Rash

⬜Artificial Joints ⬜Diabetes ⬜Jaw Pain ⬜Stroke

⬜Asthma ⬜Epilepsy ⬜Kidney Disease ⬜Swelling of Feet or Ankles

⬜Back Problems ⬜Fainting ⬜Liver Disease ⬜Thyroid Problems

⬜Blood Disease ⬜Glaucoma ⬜Mitral Valve Prolapse ⬜Tobacco Habit

⬜Cancer ⬜Headaches ⬜Pacemaker ⬜Tonsillitis

⬜Chemical Dependency ⬜Heart Murmur ⬜Radiation Treatment ⬜Tuberculosis

⬜Chemotherapy ⬜Heart Problems ⬜Respiratory Disease ⬜Ulcer

⬜Circulatory Problems ⬜Hemophilia ⬜Rheumatic Fever ⬜Venereal Disease

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| --- | --- |
| **MEDICATIONS**  | **ALLERGIES** |
| List medications you are currently taking: Pharmacy Name Phone  | ⬜ Aspirin ⬜ Barbiturates (Sleeping pills) ⬜ Codeine ⬜ Local Anesthetic⬜ Penicillin⬜ Sulfa⬜ Latex⬜ Other |

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| **SIGNATURE**  |
| The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.  Date Signature |