HEALTH HISTORY & REGISTRATION

PATIENT'S INFORMATION

Name: _____E-Mail :_____

Social Security #: _____Date Of Birth: _____

Residence: _____ City: _____ State_____ Zip Code: _____

Mailing Address: _____ City: _____ State _____ Zip Code: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Employer: _____Occupation: _____How did you hear about us? _____

Please file a claim to my insurance on my behalf _____ or I will file a claim to my insurance myself_____

POLICYHOLDER'SINFORMATION(Providing this information doesn't relieve you from your financial responsibility towards treatments rendered)

Name: _____E-Mail :_____

Social Security #: _____Date Of Birth: _____ Relation To Patient: _____

Residence: _____ City: _____ State_____ Zip Code: _____

Mailing Address: _____ City: _____ State _____ Zip Code: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Employer: _____ Occupation: _____

DENTAL INSURANCE INFORMATION*(Providing this information doesn't relieve you from your financial responsibility towards treatments rendered)*

Insurance Company: _____ Insurance Company Telephone: _____

Group Number: _____Subscriber ID number: _____

AUTHORIZATION

I authorize and give informed consent to my dental provider to perform agreed upon procedures that isnecessary for proper diagnosis and dental care. These may include but are not limited to, diagnostic(radiographs and oral exams), therapeutic procedures, local anesthesia and the use of other medications. I confirm that the information on this page and the medical history are correct to the best of my knowledge. I hereby authorize insurance payments to go directly to the dental office. Should I receive payment from insurance company in error, I will forward that payment to Bethesda Dental Health upon receipt.**I understand that I am responsible for the cost of the agreed upon treatment and services rendered regardless of my insurance benefits.**
I also authorize Bethesda Dental Health to discuss my protected health and account informationwith the persons listed below:

Name and Relationship: _____

Patient/ Legal Guardian/Parent Signature_____Date_____

DENTAL HISTORY

How long has it been since you last saw a dentist? _____

What did you have done at that time? _____

What is the reason for today's visit? _____

Date of last dental x-rays? _____When was your last dental cleaning?_____

Do you want whiter teeth? _____Is there anything you would like to change about your smile? _____

Have you been told that you grind your teeth? ____Are your facial muscles sore or tense when you wake up?_____

Are your teeth or gums sensitive?_____ Do you wear dentures? _____ How long have you had them?_____

MEDICAL HISTORY

Do you have or ever had?

Yes___ No___ Arthritis

Yes___ No___ Diabetes

Yes ___No___ Convulsions /Dizzy Spells

Yes___ No___ Heart Surgery

Yes ___No___ HIV Positive/AIDS

Yes ___ No___ Sexually Transmitted Diseases

Yes ___ No___ Cancer

Yes___ No___ High Blood Pressure

Yes___ No___ Epilepsy

Yes___ No___ Jaundice/Liver Disease

Yes___ No___ Kidney Problems/Dialysis

Yes___ No___ Tuberculosis

Yes___ No___ Joint Replacement (including hip)

Yes___ No___ Rheumatic Fever

Yes ___ No___ Stroke

Yes___ No___ Heart Murmur requiring premedication

Yes___ No___ Mitral Valve Prolapse

Yes___ No___Hepatitis A,B,C

Yes___ No___ Asthma/Breathing Problems

Yes___ No___ Low Blood Pressure

Yes___ No___ Hyperthyroid/Hypothyroid

Yes___ No___ Radiation Therapy

Yes___ No___ Bleeding Disorder

Yes___ No___ Other_____

Have you had any reactions to local anesthetic (Novocain)? _____

Are you allergic to? ____Aspirin ____Sulfa ____Codeine ____Penicillin ____Other_____

Are you under the care of a physician? Yes/No If yes please explain_____

_____

Are you currently taking any medications (prescriptions or over the counter, i.e., aspirin, birth control pills)? Yes/No If yes, please list all medications: _____

FEMALE PATIENTS

Are you pregnant? Yes/No If yes, due date: _____

Patient's Name:_____Parent's Name/Legal Gaurdian's Name:_____

Patient/Legal Gaurdian/Parent Signature: _____Date: _____

Doctor Signature: _____ Date: _--_____