DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

COUNTRY CLUB DENTAL CARE
1025 60th Street
West Des Moines, IA 50266

Telephone: (515) 222-1244

Date ________________ Home Phone (______) ________________ Cell Phone (______) ________________

PATIENT INFORMATION

Name ______________________________ SS/HIC/Patient ID# ________________
Last Name First Name Middle Initial

Address ______________________________ E-mail ________________

City ______________________________ State ________ Zip ________________

Sex ☐ M ☐ F Age ______ Birthdate ________________ ☐Married ☐Widowed ☐Single ☐Minor
☐Separated ☐Divorced ☐Partnered for ____ years

Patient Employer/School ______________________________ Occupation ________________

Employer/School Address ______________________________ Employer/School 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 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 ______________________________

Group # ______________________________ Subscriber # ________________

Names of other dependents covered under this plan ______________________________

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional dental insurance? ☐Yes ☐ No

Subscriber Name ________________ Birthdate ________________ Relation to Patient ________________

Address (If different from patient's) ______________________________ Phone (______) ________________

City ______________________________ State ________ Zip ________________

Subscriber Employed by ______________________________ Business Phone (______) ________________

Insurance Company ______________________________ Soc. Sec. # ________________

Group # ______________________________ Subscriber # ________________

Names of other dependents covered under this plan ______________________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________ and assign directly to
Name of Insurance Company(ies)
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 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

DENTAL HEALTH HISTORY
(Confidential)

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
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

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

MEDICAL HISTORY

Physician's Name ______________________ Date of Last Visit ______________________

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

Have you ever taken any of the group of osteoporosis drugs collectively referred to as "biphospates?" These include, but not limited to, Evista (brand name of raloxifene), Fosamax (alendronate), Actonel/Atelvia (risedronate), Reclast (zoledronic acid), Bonivia (Ibandronate), Aredia (pamidronate disodium)? ☐ 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 date(s) ______________________

(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
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

____

____

Pharmacy Name ______________________

Phone (____) ______________________

ALLERGIES

- ☐ 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 ______________________