

**DENTAL
REGISTRATION
AND HISTORY**

(PLEASE PRINT)

COUNTRY CLUB DENTAL CARE1025 60th Street
West Des Moines, IA 50266
Telephone: (515) 222-1244**PATIENT INFORMATION**

Date _____ Home Phone (_____) _____ Cell Phone (_____) _____

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 should 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 form patient) _____ Phone (_____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Insurance Company _____

Group# _____ Subscriber # _____

Name of other dependents covered on plan _____

ADDITIONAL DENTAL INSURANCE

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

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different form patient) _____ Phone (_____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Insurance Company _____ Soc Sec # _____

Group# _____ Subscriber # _____

Name of other dependents covered on plan _____

ASSIGNMENT AND RELEASE

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

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 "biphosphates?" These include, but are not limited to, Evista (brand name of raloxifene), Fosamax (alendronate), Actonel/Atelvia (risedronate), Reclast (zoledronic acid), Bonivia (Ibandronate), Aredia (pamidronate disodium)? ☐ Yes ☐ No

In the past two years, have you had any illnesses or operations, including cataracts? _____

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 Take birth controls pills? ☐ Yes ☐ No

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

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

MEDICATIONS

List the medications you are currently taking:

Pharmacy Name _____

Phone (____) _____

ALLERGIES

- | | |
|--|--------------------------------------|
| ☐ Aspirin | ☐ Sulfa |
| ☐ Barbiturates (Sleeping Pills) | ☐ Latex _____ |
| ☐ Codeine | ☐ Other _____ |
| ☐ Local Anesthetic | _____ |
| ☐ Penicillin | |

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 _____