



BRANDI HOWARD-STICKEL & ASSOCIATES, DDS, LLC

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DENTAL REGISTRATION & HISTORY

1. PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom May We Thank for Referring You? _____

2. PATIENT INFORMATION

Who is Responsible For This Account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is Patient Covered by Additional Insurance? _____

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____

3. PHONE NUMBERS

Home _____ Work _____ Cell _____

Email _____ Best Time to Reach You _____

IN CASE OF EMERGENCY CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work/Cell Phone _____

4. DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____

City/State _____

Date of Last Dental Visit _____

Date of Last Dental X-Rays _____

Check "Yes" or "No" where indicated for all that apply:

Would You Like Whiter Teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	Burning Sensation on Tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth Breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad Breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Chew on One Side of Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth Pain, Brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarette, Pipe, or Cigar Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on Lips/Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Clicking or Popping Jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Around Ear <input type="checkbox"/> Yes <input type="checkbox"/> No
	Dry Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
	Fingernail Biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Cold <input type="checkbox"/> Yes <input type="checkbox"/> No
	Food Collection between Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
	Foreign Objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity When Biting <input type="checkbox"/> Yes <input type="checkbox"/> No
	Grinding Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums Swollen/Tender <input type="checkbox"/> Yes <input type="checkbox"/> No
	Gums Swollen/Tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores/Growths in Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw Pain/Tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How Often do You Floss _____
	Lip/Cheek Biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How Often do You Brush _____
	Loose Teeth/Broken Fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	

5. HEALTH HISTORY

Physician's Name _____

Date of Last Visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlett Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (Type _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Abnormally, with Extraction or Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Feet/Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough; Persistent or Bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or Growth on Head or Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Women; Are You:

Pregnant? Yes, _____ Months No

Nursing? Yes No

Taking Birth Control Pills? Yes No

MEDICATIONS

List medications you are currently taking:

Pharmacy Name _____

Phone _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Codeine	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Iodine	_____
<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Local Anesthetic	_____

X

Signature of Patient or Parent of Minor

6. UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? Yes No If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____