Robert J. Asp, DDS
& Associates

Live Life Smiling!

Dental Registration and History

Patient Information

Date _____

Social Security # _____

Patient Name (Last, First, MI) _____

_____

Address _____

City _____

State _____ Zip _____

Sex ☐ Male ☐ Female Age _____

Birthdate _____

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

☐ Married ☐ Single ☐ Separated ☐ Divorced

☐ Widowed ☐ Minor ☐ Partnered for _____ years

Spouse's Name _____

Spouse's Birthdate _____

Spouse's Social Security # _____

Spouse's Employer _____

Dental Insurance

Subscriber's Name _____

Relationship to patient _____

Insurance Co. _____

Group # _____

Is patient covered under additional insurance? Y/N

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Contact Information

Home (_____) _____

Work (_____) _____ EXT _____

Cell Phone (_____) _____

Email _____

On a scale of 1-5, please rank your preferred method of contact.

Email _____ Text Message _____

Home # _____ Cell # _____ Work # _____

This office may leave messages on voice mail, an answering machine, or with a family member in regards to my or my family's appointments and necessary information
(Please initial) _____

Emergency Contact

Name _____

Relationship _____

Home (_____) _____

Work or Cell Phone (_____) _____

How Did You Hear About Us?

Referred by _____

☐ Website ☐ Newspaper _____

☐ Billboard ☐ Facebook ☐ Word of Mouth

☐ Other _____

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 dentist 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. I authorize the use of photos for marketing or educational purposes in accordance with HIPPA regulations. This consent will end when my current treatment plan is completed or one year from the date signed above.

_____
Signature of Patient, Parent, Guardian or Personal Rep.

_____
Please Print Name of Patient, Parent, Guardian, or Personal Rep

Medical History

Are you in good health? _____

Are you now under the care of a physician? If yes, what are you being treated for? _____

_____

Physician's Name _____

Address _____

Phone (_____)_____

Date of Last Visit _____

Has a doctor or dentist recommended that you take antibiotics prior to dental treatment?_____

Have you had any serious illnesses, operations, or hospitalizations in the past 3 years? If yes, describe___

_____

Have you ever taken medication for osteoporosis? ____

If yes, when did you start or discontinue taking?_____

_____

Have you ever taken any of the group of drugs referred to as "fen-phen?"_____

Do you currently use tobacco? If yes, describe_____

_____

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

AIDS/HIV	☐Yes	☐No	Glaucoma	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Anemia	☐Yes	☐No	Headaches	☐Yes	☐No	Skin Rash	☐Yes	☐No
Arthritis, Rheumatism	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Special Diet	☐Yes	☐No
Artificial Heart Valves	☐Yes	☐No	Heart Problems	☐Yes	☐No	Stroke	☐Yes	☐No
Artificial Joints	☐Yes	☐No	Hepatitis Type ____	☐Yes	☐No	Swollen Feet/Ankles	☐Yes	☐No
Asthma	☐Yes	☐No	Herpes	☐Yes	☐No	Swollen Neck Glands	☐Yes	☐No
Back Problems	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Thyroid Problems	☐Yes	☐No
Bleeding Abnormally	☐Yes	☐No	Jaundice	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Blood Disease	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Cancer	☐Yes	☐No	Liver Disease	☐Yes	☐No	Tumor of Head/Neck	☐Yes	☐No
Chemical Dependency	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No	Ulcer	☐Yes	☐No
Chemotherapy	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No	Venereal Disease	☐Yes	☐No
Circulatory Problems	☐Yes	☐No	Nervous Problems	☐Yes	☐No	Weight Loss, unexplained	☐Yes	☐No
Congenital Heart Lesions	☐Yes	☐No	Pacemaker	☐Yes	☐No			
Cortisone Treatments	☐Yes	☐No	Psychiatric Care	☐Yes	☐No	**For Women:**		
Cough, persistent or bloody	☐Yes	☐No	Radiation Treatment	☐Yes	☐No	Are you pregnant?	☐Yes	☐No
Diabetes	☐Yes	☐No	Respiratory Disease	☐Yes	☐No	Due Date_____		
Emphysema	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No	Are you nursing?	☐Yes	☐No
Epilepsy	☐Yes	☐No	Scarlet Fever	☐Yes	☐No	Taking birth control?	☐Yes	☐No
Fainting or Dizziness	☐Yes	☐No	Shortness of Breath	☐Yes	☐No			

Please list any medications you are taking (including over-the-counter): _____

_____

_____

Pharmacy Name _____

Please mark if you have any of the following allergies:

☐ Aspirin ☐ Codeine ☐ Barbiturates

☐ Iodine ☐ Latex ☐ Local Anesthetic

☐ Penicillin ☐ Sulfa ☐ Other_____

Pharmacy Phone (_____) _____

Dental History

Reason for today's visit _____

_____

_____

Former Dentist _____

City/State _____

Date of last dental visit_____

How often do you brush?_____

How often do you floss?_____

Please mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	☐ Yes	☐ No	Gums swollen or tender	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No	Injuries to face/mouth	☐ Yes	☐ No
Blisters on lips/mouth	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Cigarette, pipe, cigar smoking	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Grinding or clenching teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Sensitivity to sweets	☐ Yes	☐ No
			Sensitivity when biting	☐ Yes	☐ No
			Sores or growths on mouth	☐ Yes	☐ No