PATIENT'S DENTAL HISTORY

Reason for today's visit _____
_____

Former Dentist_____***City/State***_____
Date of Last Dental Visit_____ ***Date of last dental X-rays***_____

MARK YES OR NO TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Bad Breath_____	Yes[ ] No[ ]
Bleeding Gums_____	Yes[ ] No[ ]
Blisters on Mouth_____	Yes[ ] No[ ]
Chew on ONE Side of Mouth_____	Yes[ ] No[ ]
Clicking or Popping of Jaw_____	Yes[ ] No[ ]
Dry Mouth_____	Yes[ ] No[ ]
Fingernail Biting_____	Yes[ ] No[ ]
Food Collection between Teeth (more than normal) _____	Yes[ ] No[ ]
Grinding Teeth_____	Yes[ ] No[ ]
Gums Swollen & Tender_____	Yes[ ] No[ ]
Jaw Pain or Tiredness _____	Yes[ ] No[ ]
Lip or Cheek Biting _____	Yes[ ] No[ ]
Loose Teeth or Broken Fillings_____	Yes[ ] No[ ]
Mouth Breathing_____	Yes[ ] No[ ]
Mouth Pain, Brushing_____	Yes[ ] No[ ]
Braces (Orthodontic Treatment)_____	Yes[ ] No[ ]
Pain around Ears_____	Yes[ ] No[ ]
Gum Disease(Periodontal Disease)_____	Yes[ ] No[ ]
Sensitivity to Hot /Cold_____	Yes[ ] No[ ]
Sensitivity to Sweets _____	Yes[ ] No[ ]
Sensitivity when Biting _____	Yes[ ] No[ ]
Sores in your Mouth _____	Yes[ ] No[ ]
Do you use any form of Tobacco_____	Yes[ ] No[ ]
Are you having any PAIN at this TIME _____	Yes[ ] No[ ]
Are you NERVOUS about having DENTAL Treatment_____	Yes[ ] No[ ]
Have you ever had a BAD EXPERIENCE in a Dental Office _____	Yes[ ] No[ ]

How often do you FLOSS? _____ & BRUSH? _____
Have you LOST any TEETH? _____
Were REPLACEMENTS discussed for Missing Teeth? _____
Do you consume Sugar Products between Meals? _____
Do you Feel you have Good Teeth? _____
Are you Happy with the Appearance of your teeth? _____
_____
_____

Today's Date_____

DENTAL REGISTRATION & HISTORY

***PATIENT'S NAME*_____*BIRTHDATE*_____**
[ ]Single [ ]Married [ ]Divorced [ ]Child

NAME OF: []PARENT []SPOUSE []GUARDIAN _____

Patient's Address Information

Street Address_____CITY_____ST_____ZIP_____
Home #_____ Work#_____ Cell#_____
E-mail_____ Best way to contact you._____
{ }PATIENT'S { }PARENT'S EMPLOYER _____YRS Employed___
ADDRESS_____PRESENT POSITION_____
{ }SPOUSE { }GUARDIAN EMPLOYER_____YRS Employed___
ADDRESS_____PRESENT POSITION_____
Patient's nearest Relative_____Phone_____
ADDRESS _____
Spouse nearest Relative_____Phone_____
ADDRESS_____
PATIENT'S SSN#_____
SPOUSE/PARENT/GUARDIAN SSN#_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____
Relation to PATIENT_____
Type of Payment: [ ] CASH [ ]CHECK [ ]CREDIT CARD

DENTAL INSURANCE

INSURANCE CO._____**GROUP #**_____
ADDRESS_____**CITY**_____**ST**_____**ZIP**_____
TELEPHONE #_____**SUBSCRIBER NAME**_____
BIRTHDATE_____ **SSN#** _____**Relation to Pt**_____

Is Patient covered by secondary dental insurance? [ ]YES [ ] NO

2nd INSURANCE CO. _____**GROUP#**_____
ADDRESS_____**CITY**_____**ST**_____**ZIP**_____
TELEPHONE_____**SUBSCRIBER NAME**_____
BIRTHDATE_____**SSN#**_____**Relation to Pt**_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my Dependents) have insurance coverage with _____and assign directly to Dr. Dennis P. Morehart, D.D.S. 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 TO PATIENT_____