Cooke, Richardson & Overstreet, D.D.S.

Adult Dental Registration and History

1. Patient Information

Date: _____

Patient Name: _____
Last Name First name Middle Initial

Date of Birth: _____

Sex: Male: _____ Female: _____ Age: _____

Social Security #_____

Address: _____
City: _____
State: _____ Zip Code: _____

_____ Married _____ Widowed ____ Single ____ Minor
_____ Separated _____ Divorced ____ Partnered for ____years

Patient Employer / School: _____
Occupation: _____
Employer/School Address:
_____
_____
Employer/School Phone Number: (___) _____- _____
Spouse's Name: _____
Spouse's Date of Birth: -_____
Spouse's Social Security Number: _____
Spouse's Employer: _____

Whom may we thank for referring you? _____

2. Phone Numbers and E-Mail:

Home: (____) _____ -_____
Work: (____) _____ -_____
Cell: (____) _____ -_____
Other: (____) _____-_____
E-Mail:_____

Best time and place to reach you: _____

IN CASE OF AN EMERGENCY: Please give two contact names
(Specify spouse and someone who does not live in your household)

Name: _____
Relationship to you: _____
Home Number: _____
Work Number: _____

Name: _____
Relationship to you: _____
Home Number: _____
Work Number: _____

3. Dental Insurance

Who is responsible for the account? _____

Subscriber name if different from patient: _____

Relationship to patient: _____

Subscriber's Date of Birth: _____

Subscriber's Social Security Number: _____

Subscriber's Policy / ID Number: _____

Group Number: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone Number: (____) _____-_____

Do you have secondary insurance? _____

Subscriber name if different from patient: _____

Relationship to patient: _____

Subscriber's Date of Birth: _____

Subscriber's Social Security Number: _____

Subscriber's Policy / ID Number: _____

Group Number: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone Number: (____) _____-_____

4. Assignment and Release of Insurance Benefits

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to
(Name of Insurance Company)
Drs. Cooke, Richardson & Overstreet all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my healthcare 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. This content will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative:

_____
Please print name of Patient, Parent, Guardian or Personal Representative:

_____ _____
Date Relationship to Patient

5. Dental History

Reason for today's visit: _____
Former Dentist: _____
City/State: _____
Date of last dental visit: _____
Date of last x-rays: _____

Please place an X mark to indicate if you have had any of the following:

__ Bad Breath
__ Bleeding Gums
__ Blisters on lips or mouth
__ Burning sensation on tongue
__ Chew on one side of mouth
__ Cigarette, pipe or cigar smoking
__ Clicking or popping jaw
__ Dry Mouth
__ Fingernail biting
__ Orthodontic treatment
__ Periodontal treatment
__ Sensitivity to cold
__ Sensitivity to heat
__ Sensitivity to sweets
__ Sensitivity when biting
__ Food Collection between teeth
__ Sores or growths in mouth
__ Grinding teeth
__ Gums swollen or tender
__ Jaw pain or tiredness
__ Lip or cheek biting
__ Loose teeth or broken fillings
__ Mouth breathing
__ Mouth pain, brushing
__ Pain around ear

How often do you floss?
_____
How often do you brush?
_____

6. Health History

__ AIDS/HIV
__ Anemia
__ Arthritis, Rheumatism
__ Artificial Heart Valves
__ Artificial Joints
__ Back Problems
__ Bleeding (with extractions or surgery)
__ Blood Disease
__ Cancer
__ Chemical Dependency
__Chemotherapy
__Circulatory Problems
__ Congenital Heart Lesions
__ Cortisone Treatments
__ Cough, persistent or bloody
__ Diabetes
__ Emphysema
__ Bisphosphonate therapy
__ Epilepsy
__ Fainting or dizziness
__ Glaucoma
__ Headaches
__ Heart Murmur
__ Hepatitis Type
__ Herpes
__ High Blood Pressure
__ Jaundice
__ Contact lenses
__ Kidney Disease
__ Liver Disease
__ Low Blood Pressure
__ Mitral Valves Prolapse
__ Nervous Problems
__ Pacemaker
__ Psychiatric Care
__ Radiation treatments
__ Respiratory Disease
__ Rheumatic Fever
__ Scarlet Fever
__ Shortness of breath
__ Sinus Troubles
__ Special Diet
__ Stroke
__ Swollen Feet or ankles
__ Swollen Neck Glands
__ Thyroid Problems
__ Tonsillitis
__ Tuberculosis
__ Tumor or growth on head or neck
__ Ulcer
__ Venereal Disease
__ Weight Loss, unexplained

Women:
Are you pregnant? _____ Due date: _____
Are you nursing? _____
Are you taking birth control pills? _____

7. Medications

Please list all medications you are currently taking and the correlating diagnosis:

_____
_____
_____
_____

Pharmacy Name: _____
Pharmacy Phone Number: (_____) _____-_____

8. Allergies

Aspirin	_____	Local Anesthetic	_____
Barbiturates (Sleeping Pills)	_____	Penicillin	_____
Codeine	_____	Sulfa	_____
Iodine	_____	Other	_____
Latex	_____		_____

9. Additional information:

Is there any additional information you would like to share with our office? Hobbies, interests, etc?

_____
_____
_____
_____

10. Thank you for taking this time to fill out our patient information sheet. We look forward to assisting you and your family with your dental health needs.