Arsmiles
FAMILY & COSMETIC DENTISTRY

Dental Registration and Health History Form

Patient Information

Date *

Month Day Year

Patient Name *

First Name Middle Name Last Name

Address *

Street Address

State

City

Zip Code

Gender *

Please Select

Age

Date of Birth *

Marital Status

Please Select

Patient SS Number

Occupation

Employer

Employer Address

City, State, Zip

Employer Phone Number

Please enter a valid phone number.

Spouse's Name

Date of Birth *

SS Number

Occupation

Spouse's Employer

How did you hear about us?

Please Select

Name of the friend

If "Other" Please Explain

Phone Numbers

Cell Phone Number *

Please enter a valid phone number.

Home Phone Number

Please enter a valid phone number.

Other Phone Number

Please enter a valid phone number.

Email *

example@example.com

In Case of Emergency, Contacts

(Specify someone who does not live in your household)

Name *

Relationship *

Cell Phone Number *

Please enter a valid phone number.

Home Phone Number

Please enter a valid phone number.

Dental Insurance

Who is responsible for this account?

Relationship to Patient

Insurance Co.

Group Number

Is the patient covered by additional insurance? *

◯ Yes ◯ No

Subscriber's Name

Date of Birth *

SS Number

Relationship to Patient

Insurance Co.

Group Number

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with **{insuranceCo}, {insuranceCo67}** and assign it directly to **Dr. Chegini / Arsmiles Family and Cosmetic Dentistry** 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

Name *

First Name Last Name

Date *

Month Day Year

Relationship

Signature

Dental History

Reason for today's visit

Former Dentist

City / State

Date of last dental visit

Month Day Year

Date of last dental X-rays

Month Day Year

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

Bad Breath * ◯ Yes ◯ No

Bleeding gums * ◯ Yes ◯ No

Blisters on lips or mouth * ◯ Yes ◯ No

Burning sensation on tongue * ◯ Yes ◯ No

Chew on one side of mouth * ◯ Yes ◯ No

Jaw pain or tiredness / TMD * ◯ Yes ◯ No

Grinding or Clenching teeth / Bruxism * ◯ Yes ◯ No

Clicking or popping jaw * ◯ Yes ◯ No

Dry mouth * ◯ Yes ◯ No

Fingernail biting * ◯ Yes ◯ No

Food collection between the teeth * ◯ Yes ◯ No

Foreign objects * ◯ Yes ◯ No

Gums swollen or tender * ◯ Yes ◯ No

Lip or cheek biting * ◯ Yes ◯ No

Loose teeth or broken fillings * ◯ Yes ◯ No

Mouth breathing * ◯ Yes ◯ No

Mouth pain, brushing * ◯ Yes ◯ No

Pain around ear * ◯ Yes ◯ No

Orthodontic treatment * ◯ Yes ◯ No

Periodontal treatment * ◯ Yes ◯ No

Sensitivity to cold * ◯ Yes ◯ No

Sensitivity to heat * ◯ Yes ◯ No

Sensitivity to sweets * ◯ Yes ◯ No

Sensitivity when biting * ◯ Yes ◯ No

Sores or growths in your mouth * ◯ Yes ◯ No

Tongue scrubbing? * ◯ Yes ◯ No

How often do you floss?

How often do you brush?

Health History

Physician's Name

First Name Last Name

Phone Number

Please enter a valid phone number.

Date of last visit

Month Day Year

Please place a select on "Yes" or "No" to indicate if you have had any of the following.

Heart Condition * ◯Yes ◯No

Heart Attack * ◯Yes ◯No

Heart Surgery * ◯Yes ◯No

Chest Pain (Angina) * ◯Yes ◯No

Congenital Heart Disease * ◯Yes ◯No

Stroke * ◯Yes ◯No

High Blood Pressure * ◯Yes ◯No

Mitral Valve Prolapse * ◯Yes ◯No

Artificial Heart Valve * ◯Yes ◯No

Rheumatic Fever * ◯Yes ◯No

Heart Murmur * ◯Yes ◯No

Heart Pacemaker * ◯Yes ◯No

Blood Disorder * ◯Yes ◯No

Anemia * ◯Yes ◯No

Sickle Cell Disease * ◯Yes ◯No

Hemophilia * ◯Yes ◯No

Abnormal Bleeding * ◯Yes ◯No

Bruise Easily * ◯Yes ◯No

Circulatory Problems * ◯Yes ◯No

Blood Transfusion * ◯Yes ◯No

Ulcers * ◯Yes ◯No

GI Problems * ◯Yes ◯No

Crohn's Disease * ◯Yes ◯No

Diverticulitis * ◯Yes ◯No

Diabetes * ◯Yes ◯No

Glaucoma * ◯Yes ◯No

Emphysema * ◯Yes ◯No

Heart problems * ◯Yes ◯No

Chronic Cough * ◯Yes ◯No

Tuberculosis (T.B) * ◯Yes ◯No

Asthma * ◯Yes ◯No

Hay Fever * ◯Yes ◯No

Sinus Trouble * ◯Yes ◯No

Allergies or Hives * ◯Yes ◯No

Latex Sensitivity * ◯Yes ◯No

Liver Disease * ◯Yes ◯No

Hepatitis * ◯Yes ◯No

Type *

Yellow Jaundice * ◯Yes ◯No

Aids * ◯Yes ◯No

HIV Positive * ◯Yes ◯No

Venereal Disease * ◯Yes ◯No

Cold Sores / Herpes * ◯Yes ◯No

Kidney Trouble * ◯Yes ◯No

Frequent UTI * ◯Yes ◯No

Thyroid Problems * ◯Yes ◯No

Hypothyroidism * ◯Yes ◯No

Hyperthyrodism * ◯Yes ◯No

Swollen Ankles *
Yes No

Artificial Joints *
Yes No

Chronic Arthritis *
Yes No

Rheumatoid Arthritis *
Yes No

Fibromialgia *
Yes No

Cortisone Treatment *
Yes No

Osteoporosis *
Yes No

Bone Disease *
Yes No

Special or Restricted Diet *
Yes No

Celiac Disease *
Yes No

Cancer *
Yes No

Tumors or Growths *
Yes No

Chemotherapy *
Yes No

Radiation Therapy *
Yes No

Neurological Disorders *
Yes No

Epilepsy or Seizures *
Yes No

Fainting or Dizzy Spells *
Yes No

Psychiatric Care *
Yes No

Anxiety *
Yes No

Depression *
Yes No

Alcoholism *
Yes No

Drug Addiction *
Yes No

Do you smoke? *
Yes No

Chewless tobacco use? *
Yes No

Are you pregnant? *
Yes No

Medication (Dosage & Frequency)

Any other illness or hospitalizations

Allergies

Aspirin *
◯ Yes ◯ No

Local Anesthetic *
◯ Yes ◯ No

Barbiturates (Sleeping pills) *
◯ Yes ◯ No

Codeine *
◯ Yes ◯ No

Iodine *
◯ Yes ◯ No

Latex *
◯ Yes ◯ No

Metal *
◯ Yes ◯ No

Penicillin *
◯ Yes ◯ No

Sulfa *
◯ Yes ◯ No

Other *
◯ Yes ◯ No

If "Other" Please Explain *

Pharmacy

Pharmacy Name

Pharmacy Phone Number

Please enter a valid phone number.

Signature

Name *
First Name Last Name

Date *
Month Day Year