KATHY T. GIBSON, D. D. S. PATIENT REGISTRATION

ABOUT YOU

Patient's Name: _____ DOB: _____ Age: _____
Last First MI Mr. Mrs. Ms. Dr.

Parent/Guardian Name: _____ SSN: _____ TDL: _____

Street Address: _____ Employer: _____

City : _____ State: _____ Zip Code: _____ Fax #: _____

Home #: _____ Best place and times to reach you: Married: _____ Single: _____

Work#: _____ _____ Divorced: _____ Separated: _____

Cell #: _____ E-mail: _____ Widowed: _____ Child: _____

If patient is a child, name of school/college: _____

DENTAL INSURANCE INFORMATION N/A (please check box if not applicable)

Insured's Name: _____ DOB: _____ SSN: _____

Employer: _____ Group#: _____

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Relationship to the Insured: Self: _____ Spouse: _____ Child: _____ Other: _____

SPOUSE N/A _____

Name: _____ DOB: _____ SSN: _____

Employer: _____ TDL #: _____

Work #: _____ Cell #: _____

Secondary Insurance? Company: _____ Insured: _____ Group#: _____ Phone #: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Work #: _____ Other #: _____

REFERRED BY

_____ Dentist: _____ Friend: _____ Co-Worker: _____ Phone Book: _____
Family: _____ Insurance Company: _____ Other: _____

MEDICAL/DENTAL PROVIDER INFORMATION

Current Dentist: _____ Primary Physician: _____
Name Phone Name Phone

Pharmacy: _____ Other Doctor: _____
Name Phone Name Phone

I understand that payment is due in full at the time of treatment unless prior arrangements have been made. If insurance assignment is accepted for any visit, I understand that I am responsible for paying any estimated co-payment or deductible on the day of treatment.

_____ _____
Patient/Responsible Party Signature Date

DENTAL HISTORY

Present Dental Complaints: _____

Date of last dental exam: _____ Date of recent x-rays: _____

Bleeding Gums?	Y___ N___	Clicking of Jaw?	Y___ N___	Lip/Cheek Biting?	Y___ N___
Hot/Cold Sensitivity?	Y___ N___	Pain in Jaw or Ear?	Y___ N___	Orthodontics?	Y___ N___
Sweet/Sour Sensitivity?	Y___ N___	Difficulty w/ Chewing?	Y___ N___	Loose Teeth?	Y___ N___
Pain with Teeth?	Y___ N___	Difficulty w/ Opening?	Y___ N___	Clenching/Grinding?	Y___ N___
Frequent Headaches?	Y___ N___	Pain w/ Extractions?	Y___ N___	Periodontal Treatment?	Y___ N___
Nightguard?	Y___ N___	Fear of Dental Work?	Y___ N___	Partials/Dentures?	Y___ N___

KATHY T. GIBSON, D. D. S. PATIENT REGISTRATION PAGE 2

MEDICAL HISTORY

Date of last physical exam:_____

Hospitalizations or serious illnesses:_____

Medications, including OTC, vitamins and herbal:_____

ALLERGIES

Are you allergic to or have you reacted adversely to any of the following?

Erythromycin	Y___ N___	Aspirin	Y___ N___
Dental Anesthetics	Y___ N___	Codeine	Y___ N___
Latex	Y___ N___	Jewelry	Y___ N___
Penicillin	Y___ N___	Metals	Y___ N___
Tetracycline	Y___ N___		

Please list any other drugs and/or materials you are allergic to:

_____
_____
_____

Do you have, or have you ever had any of the following: (If "yes", please explain)

Abnormal Bleeding	Y___ N___	Herpes/Fever Blisters	Y___ N___	
Alcohol/Drug Abuse	Y___ N___	High Blood Pressure	Y___ N___	
Anemia	Y___ N___	HIV+/AIDS	Y___ N___	Date Contracted_____
Arthritis	Y___ N___	Kidney Problems	Y___ N___	
Artificial Joints/Valves	Y___ N___	Liver Disease	Y___ N___	
Asthma	Y___ N___	Low Blood Pressure	Y___ N___	
Blood Transfusion	Y___ N___	Mitral Valve Prolapse	Y___ N___	
Bruise Easily	Y___ N___	Often Thirsty	Y___ N___	
Cancer/Chemotherapy/		Pacemaker	Y___ N___	Date Placed_____
Radiation Treatment	Y___ N___	Pain w/ Exertion	Y___ N___	
Colitis	Y___ N___	Prolonged Bleeding	Y___ N___	
Communicable Disease	Y___ N___	Psychiatric Problems	Y___ N___	
Congenital Heart Defect	Y___ N___	Pulmonary Disease	Y___ N___	
Contact Lenses	Y___ N___	Reactive Airway Disease	Y___ N___	
Diabetes	Y___ N___	Respiratory Disease	Y___ N___	
Difficulty Breathing	Y___ N___	Rheumatic/Scarlet		
Emphysema	Y___ N___	Fever	Y___ N___	Date_____
Epilepsy/Seizures	Y___ N___	Shingles	Y___ N___	
Fainting Spells	Y___ N___	Shortness of Breath	Y___ N___	
Frequent Headaches	Y___ N___	Sickle Cell Disease/Trait	Y___ N___	
Glaucoma	Y___ N___	Sinus Problems	Y___ N___	
Hayfever	Y___ N___	Stent	Y___ N___	Date Placed_____
Heart Attack	Y___ N___	Stroke	Y___ N___	Date_____
Heart Murmur	Y___ N___	Thyroid Problems	Y___ N___	
Heart Surgery	Y___ N___	Tuberculosis (TB)	Y___ N___	
Hemophilia	Y___ N___	Ulcers	Y___ N___	
Hepatitis A?B?C?	Y___ N___	Valvular Heart Disease	Y___ N___	
Other_____			Y___ N___	

Do you smoke? Y___ N___ Cigarettes____ Pipe____ Cigars____ Other_____ How much?_____
Do you use chewing tobacco? Y___ N___
Are you pregnant? Y___ N___ _____weeks
Are you trying to get pregnant? Y___ N___ Are you nursing? Y___ N___
Are you taking birth control pills? Y___ N___
Do you participate in active recreational activities? Y___ N___ If so, describe:_____

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims if necessary.
- The information that I have given on this form is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that is my responsibility to inform this office of any changes in my medical status.

_____ _____ _____ _____
Patient/Guardian Signature Date Doctor Signature Date