Kenneth L. Egger, DDS, P.C.
DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION ***Today's Date***_____

Patient_____Address_____

City_____State_____Zip_____ Sex: M F Age_____ Birthdate_____

Marital Status:_____SS#_____ Driver Lic.#_____

Occupation_____Employer_____ Employer Address_____

_____Spouse's Name_____Birthdate_____

SS#_____Occupation_____ Spouse's Employer_____

FINANCIAL RESPONSIBILITY

Who is responsible for this account?_____Relationship to Patient_____

Address_____Phone #_____

Birthdate_____SS#_____Driver Lic.#_____

PHONE NUMBERS

Home_____Work_____ Ext._____Mobile_____

Spouse's Work_____Best time and place to reach you_____

In case of an emergency, contact (someone who does not live with you): _____

Relationship_____Home Phone_____ Work Phone_____

DENTAL INSURANCE

Dental Insurance?_____Subscriber's Name_____Employer_____

Name of Insurance Company_____ Group #_____

SS#_____Birthdate_____Employer Phone_____

Additional Insurance?_____Subscriber's Name_____Employer_____

Name of Insurance Company_____ Group #_____

SS#_____Birthdate_____Employer Phone_____

Primary Subscriber relationship to patient_____Secondary Subscriber relationship to patient_____

STUDENTS: please supply parent's name_____Permanent Address_____

_____phone_____

MEDICATIONS: List any you are currently taking_____

_____

DENTAL HISTORY

Reason for today's visit_____Are you nervous about having dental treatment?_____

Former Dentist_____ City/State_____Date of last visit_____

Date of last dental X-rays_____Place a mark to indicate if you have 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
_____Sores or growths in your mouth
_____Fingernail biting
_____Food collection between the teeth
_____Foreign objects
_____Grinding teeth
_____Gums swollen or tender
_____Jaw pain or tiredness
_____Lip or cheek biting
_____Loose teeth or broken filings
_____Mouth breathing
_____Mouth pain, brushing
_____Orthodontic treatment
_____Pain around ear
_____Periodontal treatment
_____Sensitivity to cold
_____Sensitivity to heat
_____Sensitivity when biting
_____Sensitivity to sweets

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

Are you dissatisfied with the appearance of your teeth?_____Is it important to you to keep your teeth?_____
_____

HEALTH HISTORY

Physician's Name_____Date of last visit_____
Place a mark to indicate if you have/had any of the following:

_____Aids
_____Anemia
_____Arthritis, Rheumatism
_____Artificial Heart Valves
_____Artificial Joints
_____Asthma
_____Back Problems
_____Bleeding abnormally, with Extractions or surgery
_____Blood Disease
_____Cancer
_____Chemical Dependency
_____Chemotherapy
_____Circulatory Problems
_____Congenital Heart lesions
_____Cortisone Treatments
_____Cough, persistent or bloody
_____Diabetes
_____Emphysema
_____Do you wear contact lenses?
_____Epilepsy
_____Fainting or dizziness
_____Glaucoma
_____Headaches
_____Heart Problems
_____Heart Murmur
_____Hepatitis - Type_____
_____Herpes
_____High Blood Pressure
_____HIV Positive
_____Jaundice
_____Jaw Pain
_____Kidney Disease
_____Liver Pressure
_____Low Blood Pressure
_____Mitral Valve Prolapse
_____Nervous Problems
_____Pacemaker
_____Women: are you pregnant? Due Date_____
_____Radiation Treatment
_____Respiratory Disease
_____Rheumatic Fever
_____Scarlet Fever
_____Shortness of Breath
_____Sinus Trouble
_____Skin Rash
_____Special Diet
_____Stroke
_____Swelling of Feet or Ankles
_____Swollen Neck Glands
_____Thyroid Problems
_____Tonsillitis
_____Tuberculosis
_____Tumor or growth on head or neck
_____Ulcer
_____Venereal Disease
_____Weight Loss, unexplained
_____Psychiatric Care

ALLERGIES

_____Aspirin
_____Barbiturates (sleeping pills)
_____Codeine
_____Latex
_____Local Anesthetic
_____Penicillin
_____Sulfa
_____Other_____

REFERRAL: Who may we thank for yours?_____