DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

STALLER DENTAL & ASSOCIATES

5869 West Atlantic Avenue, Suite A2A
Delray Beach, FL 33484
Telephone: (561) 637-9300
www.StallerDental.com

Date_____ Home Phone (_____) _____ Cell Phone (_____) _____

PATIENT INFORMATION

Patient Name _____ Social Security #: _____

Address _____ Email Address _____

City, State, Zip _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Gender: ☐ Male ☐ Female DOB: _____ ☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone (_____) _____

PRIMARY INSURANCE

Person Responsible for Account _____

Last Name First Name Middle Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. #_____

Address (If different from patient☐s) _____ Phone (_____) _____

City _____ State _____ Zip _____

Person Responsible Employee by _____ Occupation_____

Business Address _____ Business Phone (_____) _____

Insurance Company_____

Contract # _____ Group# _____ Subscriber # _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthday _____ Relationship to Patient_____

Address (if different from patient☐s) _____ Phone (_____) _____

City _____ State _____ Zip _____

Subscriber Employed by_____ Business Phone (_____) _____

Insurance Company _____ Soc. Sec # _____

Contract # _____ Group # _____ Subscriber# _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign benefits directly to Staller Dental and Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions. The above name doctor may use my health care information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for the related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental x-rays _____

Address _____

Check (☐) if you have had any of the following:

☐ Bad breath	☐ Grinding teeth/Jaw pain	☐ Sensitivity to sweets
☐ Bleeding gums	☐ Loose teeth or broken filings	☐ Sensitivity when biting
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sores or growths in your mouth
☐ Food collection between teeth	☐ Sensitivity to cold or hot	☐ Tobacco Habits

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

MEDICAL HISTORY

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints/Valves
- ☐ Asthma
- ☐ Back Problems
- ☐ Biophosphonates
  Describe:_____
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cortisone Treatment

- ☐ Cough, persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding/Hemophilia
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
  Circle One: A B C

- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental or Nervous Disorders
- ☐ Mitro Valve Prolapse
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism

- ☐ Sinus Problems
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ OTHER:_____

LIST OF MEDICATIONS

_____

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

_____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you had any past surgeries, major or minor? ☐ Yes ☐ No
  If yes, please explain: _____
- Preferred Pharmacy:_____ Phone: _____
- Name of Physician: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____

Signature of patient, parent or guardian Date