DENTAL ARTS OF WADSWORTH

416 College St
Wadsworth, OH, 44281
330-336-3131 Tel
330-335-7223 Fax

REGISTRATION & MEDICAL DENTAL history

DENTAL ARTS OF ELLET

737 Canton Road
Akron, OH, 44312
330-784-4441 Tel
330-784-3614 Fax

Date: _____ **Date of your last dental appointment:** _____

PATIENT NAME: _____ **Date of Birth**: _____ **SSN:** _____

Address: _____

Sex: M / F Age: _____ Pregnancy Y / N / NA Single Married Separated Divorced Widowed

Email: _____ Home tel: _____ Mobile: _____

SPOUSE / NEXT OF KIN / EMERGENCY information:

Name: _____ Relationship: _____ DOB: _____ SSN: _____

Address: _____

Best contact tel number: _____ Employer: _____

EMPLOYMENT INFORMATION:

Occupation: _____ Employer: _____

Address: _____Work phone: _____ ext_____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Relationship: _____ DOB: _____

Employer: _____ Work: _____ Ext: _____

Billing Address: _____

Home tel: _____ Mobile: _____ Other: _____

PROVIDER INFORMATION:

FAMILY PHYSICIAN: _____ Phone #: _____

SPECIALIST: _____ Phone #: _____

PEDIATRICIAN: _____ Phone #: _____

PHARMACY: _____ Phone #: _____

DENTAL INSURANCE INFORMATION:

1.

_____
Insured Name SSN Insurance Company

_____
Group # ID # DOB Employer

_____
Address

2.

_____
Insured Name SSN Insurance Company

_____
Group # ID # DOB Employer

_____
Address

REGISTRATION & MEDICAL DENTAL history

MEDICAL HISTORY: **ALLERGIES**_____

Please circle below any condition you may have had!

AIDS/HIV positive	Diabetes	Hypoglycemia	Venereal Disease	Rheumatic Fever
Reaction to anesthetics_____		Blood Disease	Blood Transfusion	Pacemaker
Glaucoma	Blood pressure (LOW)	Blood Pressure (HIGH)	Mitral valve prolapse	Stroke
Angina Pectoris	Heart Disease	Artificial Heart Valve	Heart Disease or Attack	Heart Murmur
Circulatory problems	Hemophilia	Swollen neck glands	Cancer _____	Leukemia
Chemotherapy	Kidney Problems	Sinus Problems	Chronic Diarrhea	Unintentional weight loss
Asthma	Tuberculosis	Respiratory concerns	Headaches	Epilepsy/Seizures
Psychiatric concerns	Mental impairment	Chemical dependency_____		Back Problems
Arthritis	Artificial Joints	Thyroid disease	Hepatitis, Jaundice or Liver Disease	
Recommendation to pre-medicate		Contact Lenses	Ulcer	

CURRENT MEDICATIONS: _____ , _____ , _____

_____ , _____ , _____ , _____

Circle one: Taking daily aspirin N / Y Pregnant N / Y Nursing N / Y Taking birth control pills N / Y

Current weight for children < 18 years: _____

DENTAL HISTORY:

Please tell us the date of your last:

Dental Visit: _____ Dental Cleaning: _____ Full Mouth X-ray: _____ Panoramic X-ray: _____

Velscope exam*: _____ Adult Fluoride treatment*: _____ Scaling and root planning*: _____

** If you never had these procedures done, please ask our staff about details*

Please tell us about today's visit:

What is the reason for the visit? _____

Do you have any concerns about today's visit? _____

_____

Are you nervous about having dental treatment Y / N Did you have an unpleasant dental exam in the past Y / N

Have you ever had adverse reactions to dental anesthesia? If so, please describe: _____

_____

Please tell us about your oral health and habits:

Do you clench or bite your teeth? Y / N	Do you have bad breath? Y / N	Do you have loose teeth? Y / N
Do you mouth breathe, awake or asleep? Y / N	Do you have sensitivity to hot/cold? Y / N	Do you feel clicking/popping of the jaw Y/N
Do you have tired jaws especially mornings? Y / N	Do you have sensitivity to sweet? Y / N	Do you smoke or chew tobacco? Y / N
Do you get cold sores or blisters? Y / N	Do you have sensitivity to chewing? Y / N	Does food get caught between teeth? Y / N

AUTHORIZATION AND RELEASE

I reviewed the information above with the patient or guardian of patient named herein. _____

Staff initials Date

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. I authorize Dr. Cristian Chirla to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

_____

Signature of patient or parent of minor Date