Robert A. Cummings, DMD

HEALTH HISTORY & REGISTRATION (PLEASE PRINT)

Patient Information

Name _____ (Last Name / First Name / Middle) Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Sex ☐M ☐F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Email Address _____ Business Phone _____ Cell Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Primary Insurance or Responsible Party

PERSON RESPONSIBLE FOR ACCOUNT _____ (Last Name / First Name / Middle) MARITAL STATUS _____

MAILING ADDRESS Street _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ WORK PHONE _____

SOCIAL SECURITY # _____ BIRTH DATE _____ CELL PHONE _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

INSURANCE CO. _____ GROUP # _____

INSURANCE CO. ADDRESS _____

Additional Insurance

PERSON RESPONSIBLE FOR ACCOUNT _____ (Last Name / First Name / Middle) MARITAL STATUS _____

MAILING ADDRESS Street _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ WORK PHONE _____

SOCIAL SECURITY # _____ BIRTH DATE _____ CELL PHONE _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

INSURANCE CO. _____ GROUP # _____

INSURANCE CO. ADDRESS _____

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a Dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?	☐	☐
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING, or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Name of Previous Dentist:		
City: State:		

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For What?		
What MEDICATIONS are you currently taking?		
Are you PREGNANT?	☐	☐
Do you SMOKE?	☐	☐

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	A.I.D.S./A.R.C./HIV Pos.	Bruise Easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Liver Disease	Asthma
Rheumatic Fever	Blood Transfusion	Hay Fever
Congenital Heart Lesions	Drug Addiction	Sinus Trouble
Mitral Valve Prolapse	Hemophilia (Bleeding Problems)	Allergies or Hives
Artificial Heart Valve	Fever Blisters	Diabetes
Heart Pacemaker	Epilepsy or Seizures	Thyroid Disease
Heart Surgery	Nervousness	Radiation Treatment
Artificial Joints (Hip, Knee)	Psychiatric Treatment	Arthritis
Anemia	Glaucoma	Cortisone Medicine
Stroke	Chemotherapy (Cancer, Leukemia)	Pain in Jaw Joints
Kidney Trouble	Venereal Disease	Alcoholism
Ulcers	(Syphilis, Gonorrhea, ect.)	Cosmetic Surgery
Sleep disorder	Sleep Apnea	Snoring

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin	Latex
Nitrous Oxide	Codeine	Penicillin	Products

Are you aware of being allergic to any other medications or substances?

If yes, please list: _____

Do you need to take **Antibiotics before dental treatment?** ☐ Yes ☐ No

If so, what do you take?

_____

FAMILY PHYSICIAN _____ PHONE NO. _____

CONSENT

I certify that I have read and understand the above information to the best of my knowledge. The above question have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Doctor to take x-rays, study models, photographs, or any diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible to all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to my overdue balance and where appropriate, credit reports may be obtained. I clearly Understand, that after 90 days, any past due balance on my account may be turned over to a collection Agency.

PATIENT Signature (Parent of Child) _____ Date _____ DENTIST Signature _____