REGISTRATION **Shrewsbury, Claywell and Oliver Dentistry**
(please print)

PATIENT INFORMATION

DATE:_______________________________

Name____ Social Security#: ____________________________
(last) (first) (MI)
Phone:________________________
Email Address: ____
Cell Phone:_________________________
Address: ____

City:____ State: ________________ Zip:___________________

Sex: □ **M** □ **F** Age_________Birthdate: ______________ □**Single** □**Married** □ **Separated** □ **Divorced** □ **Widowed**

Patient Employed by: ____ Occupation:___________________________

Business Address:____ Business Phone: ______________________

Whom may we thank for referring you? ____

Notify in case of emergency:____ Phone: ______________________________

PRIMARY DENTAL INSURANCE

Person responsible for account ____
Last Name First Name Initial
Relation to Patient _____________________________ Birthdate _____________________ Social Security# _____________________

Address (if different from pt's) ____ Phone _______________________

City ____ State ________________ Zip__________________

Employer ____ Phone _______________________________

Insurance Company ____

Contract# _____________________________ Group# _____________________ Subscriber ID#________________________

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional insurance? □ **yes** □ **no**
Subscriber Name ____ Relation ______________ Birthdate_____________________

Address (if different from pt's) ____ Phone _______________________

City ____ State_________________ Zip __________________________

Employer ____ Phone _______________________________

Insurance Company ____

Contract# _____________________Group# _____________ Subscriber ID#___________________Social Security#_________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ____
and assign directly to **Shrewsbury, Claywell and Oliver Dentistry** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
I hereby give consent to the dentist and those under his professional supervision to prescribe and perform dental treatment, anesthesia or other dental procedure deemed necessary or appropriate for overall oral hygiene health.

____ _____________________________ _____________________________
Responsible Party Signature Relationship Date

DENTAL HEALTH HISTORY
(Confidential)

Today's Date ________________________________

Patient Name ____ Birthdate ____________________________________

DENTAL HISTORY

Reason for today's visit ____

Former Dentist ____ Phone ______________________

Date of last dental visit _______________________________________ Date of last x-rays_____________________________

Check (√) if you have had problems with any of the following

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in mouth

How often do you floss? _______________________ Brush? _______________

MEDICAL HISTORY

Physician's Name ____ Date of last visit _______________

Have you had any serious illnesses or operations? __________ If yes, describe____

Have you ever had a blood transfusion? ☐ **yes** ☐ **no** If yes, give approximate dates___________________

(Women) Are you pregnant**?** ☐ **yes** ☐ **no** Nursing? ☐ **yes** ☐ **no** Birth control pills? ☐ **yes** ☐ **no**

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

- ☐ AIDS
- ☐ Alzheimers
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Aspirin Therapy
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemo Therapy
- ☐ COPD
- ☐ Cortisone Treatment
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Problem
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ MRSA
- ☐ Nervous Disorders
- ☐ NO EPI
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Tx.
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking: _________________________

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ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates(sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other

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Pharmacy Name ____ Phone _______________________

SIGNATURE/CONSENT

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

You agree, in order for us to service your account, notify you of information pertaining to your account or medical condition, or for the purposes of collection, we may contact you by telephone at any number provided by you, including wireless telephone numbers. We may also contact you via e-mail or text message using any e-mail address you provide. Methods of contact may include the use of pre-recorded and artificial voice messages, and/or use of an automated dialing device.

DATE _______________________________________ SIGNATURE ____