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ARBOR DENTAL ASSOCIATES
Douglas J. Borgman, D.D.S

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION	DENTAL INSURANCE
<p>DATE _____</p> <p>SSN/PATIENT ID# _____</p> <p>PATIENT NAME _____ (LAST NAME)</p> <p>_____ (FIRST NAME) (MIDDLE INITIAL)</p> <p>ADDRESS _____</p> <p>CITY _____</p> <p>STATE _____ ZIP _____</p> <p>Sex: M F Age _____</p> <p>Birthdate _____</p> <p><input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor</p> <p><input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years</p> <p>Patient Employer/School _____</p> <p>Occupation _____</p> <p>Employer Address _____</p> <p>Employer/School Phone (____) _____</p> <p>Spouse's Name _____</p> <p>Birthdate _____</p> <p>SS# _____</p> <p>Spouse's Employer _____</p> <p>Whom may we thank for referring you? _____</p>	<p>Who is responsible for this account? _____</p> <p>Relationship to patient _____</p> <p>Insurance Co. _____</p> <p>ID# _____ Group # _____</p> <p>Is patient covered by additional Insurance? YES NO</p> <p>Subscriber's Name _____</p> <p>Birthdate _____ SS# _____</p> <p>Relationship to Patient _____</p> <p>Insurance Co. _____</p> <p>ID# _____ Group # _____</p> <p>Assignment and Release</p> <p>I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____ Name of Insurance Company(ies)</p> <p>Dr. _____ 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 authorize the use of my signature on all insurance submissions.</p> <p>The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.</p> <p>_____ Signature of Patient, Parent, Guardian, or Personal Representative</p> <p>_____ Printed Name</p> <p>Date _____ Relationship to Patient _____</p>

PHONE NUMBERS

Home (____) _____ Work (____) _____ Ext _____ Mobile (____) _____ Email _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

DENTAL HISTORY

Reason for visit today _____	Burning sensation on tongue	YES	NO	Mouth breathing	YES	NO
_____	Chew on one side of mouth	YES	NO	Mouth pain, brushing	YES	NO
Former Dentist _____	Cigarette, pipe, or cigar smoking	YES	NO	Orthodontic treatment	YES	NO
City/State _____	Clicking or popping jaw	YES	NO	Pain around ear	YES	NO
Date of last dental visit _____	Dry mouth	YES	NO	Periodontal treatment	YES	NO
Date of last dental x-rays _____	Fingernail biting	YES	NO	Sensitivity to cold	YES	NO
	Food collection between the teeth	YES	NO	Sensitivity to hot	YES	NO
Circle YES or NO to indicate if you have had any of the following:	Foreign objects	YES	NO	Sensitivity to sweets	YES	NO
	Grinding teeth	YES	NO	Sensitivity when biting	YES	NO
Bad breath	Jaw pain or tiredness	YES	NO	Sores or growths in mouth	YES	NO
Bleeding gums	Lip or cheek biting	YES	NO	How often do you floss? _____		
Blisters on lips or mouth	Loose teeth or broken fillings	YES	NO	How often do you brush? _____		

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). YES NO

Place a circle or mark "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	YES	NO	Epilepsy	YES	NO	Radiation Treatment	YES	NO
Anemia	YES	NO	Fainting or Dizziness	YES	NO	Respiratory Disease	YES	NO
Arthritis/Rheumatism	YES	NO	Glaucoma	YES	NO	Rheumatic Fever	YES	NO
Artificial Heart Valve	YES	NO	Headaches	YES	NO	Scarlet Fever	YES	NO
Artificial Joints	YES	NO	Heart Murmur	YES	NO	Shortness of Breath	YES	NO
Asthma	YES	NO	Heart Problems	YES	NO	Sinus Trouble	YES	NO
Back Problems	YES	NO	Hepatitis Type ____	YES	NO	Skin Rash	YES	NO
Bleeding abnormally, with extractions or surgery	YES	NO	Herpes	YES	NO	Special Diet	YES	NO
Blood Disease	YES	NO	High Blood Pressure	YES	NO	Stroke	YES	NO
Cancer	YES	NO	Jaundice	YES	NO	Swollen Feet or Ankles	YES	NO
Chemical Dependency	YES	NO	Jaw Pain	YES	NO	Swollen Neck Glands	YES	NO
Chemotherapy	YES	NO	Kidney Disease	YES	NO	Thyroid Problems	YES	NO
Circulatory Problems	YES	NO	Liver Disease	YES	NO	Tonsillitis	YES	NO
Congenital Heart Lesions	YES	NO	Low Blood Pressure	YES	NO	Tuberculosis	YES	NO
Cortisone Treatments	YES	NO	Mitral Valve Prolapse	YES	NO	Tumor, growth on head or neck	YES	NO
Cough, persistent/bloody	YES	NO	Nervous Problems	YES	NO	Ulcer	YES	NO
Diabetes	YES	NO	Pacemaker	YES	NO	Venereal Disease	YES	NO
Emphysema	YES	NO	Psychiatric Care	YES	NO	Weight Loss, unexplained	YES	NO

Women:

Are you pregnant? Yes No Due Date: _____ Are you nursing? Yes No

Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking:

Pharmacy _____

Phone (____) _____

ALLERGIES

___ Aspirin	___ Local Anesthetic
___ Barbiturates (Sleeping pills)	___ Penicillin
___ Codeine	___ Sulfa
___ Iodine	___ Other _____
___ Latex	_____