Regency Dental
Donna T. Burton, DDS

Welcome to our practice. *Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.*

Patient Information

Patient Number .....

Today's date .....

First name ..... Middle initial..... Last name.....

I prefer to be called (nickname, etc.) ..... ☐ Male ☐ Female

Address (Street, City, State, ZIP) .....

Date of birth ..... Age..... Social security no. .....

Home phone (.....) ..... Work phone (.....) ..... Cell phone (.....) .....

Primary contact number (please check one) ☐ Home ☐ Work ☐ Cell Fax .....

E-mail ..... Driver's license no. .....

Employer ..... Occupation .....

Spouse's name ..... Spouse's date of birth .....

Spouse's social security no. ..... Spouse's employer .....

Whom may we thank for referring you? .....

If the patient is a child

School ..... School phone .....

Grade ..... Social security no. .....

Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Person to contact in case of emergency

Name ..... Relationship .....

City, State ..... Cell phone .....

Home phone ..... Work phone .....

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature ..... *Date* .....

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Dental History

Reason for today's visit .....

Date of last full mouth X-rays .....

Date of last dental visit ..... Date of last cleaning .....

Procedure(s) done at last dental visit .....

Previous dentist's name .....

City/State ..... Phone .....

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

How often do you have dental examinations? .....

How often do you brush your teeth? .....

What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft

How often do you floss? .....

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) .....

Do you have any dental problems now? .....

If yes to above, please describe .....

Do your gums ever bleed? ☐ Yes ☐ No
Have you ever had periodontal disease? ☐ Yes ☐ No
Have you ever had gum treatment? ☐ Yes ☐ No
Have you noticed any mouth odors or bad tastes? ☐ Yes ☐ No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No
Do you have frequent headaches? ☐ Yes ☐ No
Do you clench or grind your teeth? ☐ Yes ☐ No
Do you bite your lips or cheeks frequently? ☐ Yes ☐ No
Are your teeth sensitive to heat/cold? ☐ Yes ☐ No
Do you still have your wisdom teeth? ☐ Yes ☐ No
Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe .....

Is there anything else about your past dental treatment(s) that you would like us to know? .....

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Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No
Oral surgery? ☐ Yes ☐ No
Periodontal treatment? ☐ Yes ☐ No
Your teeth ground or bite adjusted? ☐ Yes ☐ No
A bite plate or mouthguard? ☐ Yes ☐ No
A serious injury to the mouth or head? ☐ Yes ☐ No

If so, please describe .....

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Medical History

Have you been under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

If yes, for what? .....

Physician's name ..... Phone .....

Physician's City/State .....

Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) ☐ Yes ☐ No

If yes, please explain .....

Have you ever taken Fen-Phen? ☐ Yes ☐ No

If so, how long ago? .....

Did you ever go to the doctor to check for heart problems? ☐ Yes ☐ No

Are you aware of having an allergic (or adverse) reaction to any medication or substance? ☐ Yes ☐ No

If so, which ones? .....

Do you use tobacco? ☐ Yes ☐ No

Do you use alcohol or any other controlled substance? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women only:

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Indicate which of the following you have had or have at present.

☐ Yes	☐ No	AIDS	☐ Yes	☐ No	Heart Murmur
☐ Yes	☐ No	Alcohol/Drug Abuse	☐ Yes	☐ No	Hemophilia/Abnormal Bleeding
☐ Yes	☐ No	Allergies or Hives	☐ Yes	☐ No	Hepatitis A B C (circle)
☐ Yes	☐ No	Arthritis/Rheumatism	☐ Yes	☐ No	High Blood Pressure
☐ Yes	☐ No	Artificial Heart Valve	☐ Yes	☐ No	HIV Positive
☐ Yes	☐ No	Artificial Bones/Joints/Valves	☐ Yes	☐ No	Hospitalized for Any Reason
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Kidney Trouble
☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No	Latex Sensitivity
☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No	Liver Disease
☐ Yes	☐ No	Cancer/Chemotherapy	☐ Yes	☐ No	Low Blood Pressure
☐ Yes	☐ No	Chest Pain	☐ Yes	☐ No	Lupus
☐ Yes	☐ No	Cold Sores/Herpes	☐ Yes	☐ No	Mitral Valve Prolapse
☐ Yes	☐ No	Colitis	☐ Yes	☐ No	Nervous/Anxious
☐ Yes	☐ No	Congenital Heart Disease	☐ Yes	☐ No	Neurological Disorders
☐ Yes	☐ No	Contact Lenses	☐ Yes	☐ No	Psychiatric/Psychological Care
☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No	Radiation Therapy
☐ Yes	☐ No	Chronic Cough	☐ Yes	☐ No	Rheumatic/Scarlet Fever
☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Shingles
☐ Yes	☐ No	Diet (Special/Restricted)	☐ Yes	☐ No	Sickle Cell Disease/Traits
☐ Yes	☐ No	Difficulty Breathing	☐ Yes	☐ No	Sinus Trouble
☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Swollen Ankles
☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No	Thyroid Problems
☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Tuberculosis (TB)
☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Tumors
☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Ulcers
☐ Yes	☐ No	Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Venereal Disease
☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Yellow Jaundice

Please list any serious medical condition(s) that you have ever had not listed above:

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Are you allergic to any of the following?

☐ Yes	☐ No	Aspirin	☐ Yes	☐ No	Latex
☐ Yes	☐ No	Codeine	☐ Yes	☐ No	Penicillin or Other Antibiotics
☐ Yes	☐ No	Anesthetics (for example Novocaine)	☐ Yes	☐ No	Sedatives
☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No	Sulfa Drugs
☐ Yes	☐ No	Iodine	☐ Yes	☐ No	Tetracycline
☐ Yes	☐ No	Jewelry/Metals	☐ Yes	☐ No	Other .....

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Dental Insurance

Primary carrier

Insurance co. name ..... Insurance co. phone .....

Address (Street, City, State, ZIP) .....

Group no. (Plan or Policy no.) ..... Insured's I.D. no. .....

Insured's name ..... Relationship to patient .....

Date of birth ..... Insured's social security no. .....

Insured's employer name .....

Secondary Carrier

Insurance co. name ..... Insurance co. phone .....

Address (Street, City, State, ZIP) .....

Group no. (Plan or Policy no.) ..... Insured's I.D. no. .....

Insured's name ..... Relationship to patient .....

Date of birth ..... Insured's social security no. .....

Insured's employer name .....

Person Financially Responsible for Account

Name ..... Relationship to patient .....

Social security no. ..... Phone .....

Driver's license no. ..... Date of birth .....

Address (Street, City, State, ZIP) .....

Employer .....

If patient is a minor, name of parent or legal guardian and relationship .....

Is this parent or legal guardian currently a patient in our office? ☐ Yes ☐ No

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date ..... Initials .....

Doctor's comments:

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