

**DENTAL  
REGISTRATION**  
(PLEASE PRINT)

**RIGHT TOUCH DENTAL**  
870 Crestmark Dr., Suite 100  
Lithia Springs, GA 30122

Date \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_ SS/HIC/Patient ID # \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_ E mail \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex \_\_\_ M \_\_\_ F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Married \_\_\_ Widowed \_\_\_ Single \_\_\_ Minor \_\_\_  
Separated \_\_\_ Divorced \_\_\_ Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**PRIMARY INSURANCE**

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc.Sec # \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contract # \_\_\_\_\_ Group# \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependents covered under this plan \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I Certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and  
Name of Insurance Company (ies)

Assign directly to 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.

The above-named doctor 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.

\_\_\_\_\_  
Signature of Patient, Guardian or Personal Representative Date

\_\_\_\_\_  
Please print name of Patient, Guardian or Personal Representative Relationship to Patient

**DENTAL  
HEALTH HISTORY**

**RIGHT TOUCH DENTAL**

**DENTAL HISTORY**

Reason for Today's Visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

Address \_\_\_\_\_

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

**MEDICAL 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

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 Taking birth control pills? \_\_\_Yes \_\_\_No

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

- |                            |                         |                          |                               |
|----------------------------|-------------------------|--------------------------|-------------------------------|
| ___Anemia                  | ___Cortisone Treatments | ___Hepatitis             | ___Scarlet Fever              |
| ___Arthritis, Rheumatism   | ___Cough, Persistent    | ___High Blood Pressure   | ___Shortness of Breath        |
| ___Artificial Heart Valves | ___Cough up Blood       | ___HIV/AIDS              | ___Skin Rash                  |
| ___Artificial Joints       | ___Diabetes             | ___Jaw Pain              | ___Stroke                     |
| ___Asthma                  | ___Epilepsy             | ___Kidney Disease        | ___Swelling of Feet or Ankles |
| ___Back Problems           | ___Fainting             | ___Liver Disease         | ___Thyroid Problems           |
| ___Blood Disease           | ___Glaucoma             | ___Mitral Valve Prolapse | ___Tobacco Habit              |
| ___Cancer                  | ___Headaches            | ___Pacemaker             | ___Tonsillitis                |
| ___Chemical Dependency     | ___Heart Murmur         | ___Radiation Treatment   | ___Tuberculosis               |
| ___Chemotherapy            | ___Heart Problems       | ___Respiratory Disease   | ___Ulcer                      |
| ___Circulatory Problems    | ___Hemophilia           | ___Rheumatic Fever       | ___Venereal Disease           |

**MEDICATIONS**

**ALLERGIES**

List medications you are currently taking:  
\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

- |                                  |                |
|----------------------------------|----------------|
| ___Aspirin                       | ___Sulfa       |
| ___Barbiturates (sleeping pills) | ___Latex       |
| ___Codeine                       | ___Other _____ |
| ___Local Anesthetic              | _____          |
| ___Penicillin                    |                |

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.

Date \_\_\_\_\_ Signature \_\_\_\_\_