

# REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date \_\_\_\_\_  
 SS# \_\_\_\_\_  
 Patient Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 How Long? \_\_\_\_\_ Rent  Own   
 E-mail \_\_\_\_\_  
 Sex  M  F Age \_\_\_\_\_  
 Birth Date \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered For \_\_\_\_\_ Years  
 Occupation \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_  
 Spouse's Birth Date \_\_\_\_\_  
 Spouse's SS# \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 \_\_\_\_\_  
 Acknowledgement of Receipt of Notice of Privacy Policies  
 I, \_\_\_\_\_, have received a copy of Dr. Robert J. Sex-  
 auer, Notice of Privacy Policies. I understand Dr. Robert J. Sex-  
 auer may use my health care information and may disclose such  
 information for treatment, payment, and health care operations.  
 \_\_\_\_\_ Printed Name  
 \_\_\_\_\_ Signature & Date

## 2 FINANCIAL INFORMATION

Who is financially responsible for this account?  
 \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Group# \_\_\_\_\_  
 Is patient covered by additional insurance?  Yes  No  
 Subscriber's Name \_\_\_\_\_  
 Birth Date \_\_\_\_\_ SS# \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Group # \_\_\_\_\_  
**Insurance Assignment**  
 I certify that I, and/or my dependents(s), have insurance coverage  
 with \_\_\_\_\_ and assign directly to  
Name of insurance company(ies)  
 Dr. \_\_\_\_\_  
 all insurance benefits, if any, otherwise payable to me for services rendered.  
**Financial and Personal Health Information**  
 I understand that I am financially responsible for all charges incurred dur-  
 ing treatment. I further understand that any insurance contract is between  
 my insurance carrier and myself. Dr. Robert J. Sexauer is not part of  
 that contract. As a courtesy to our valued patients we will submit your  
 insurance forms initially. If problems occur with insurance portion of your  
 obligation, the balance in full will become due in 30 days. We will provide  
 information to help you deal with your carrier. I understand that finance  
 charges will begin 60 days from date of service if the balance is not paid  
 in full. I authorize the use of my signature on all insurance submissions.  
 \_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative  
 \_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative  
 \_\_\_\_\_  
Date Relationship to Patient

## 3 PHONE NUMBERS

Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_  
 Spouse's Work (\_\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_  
 IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

## 4 HEALTH HISTORY UPDATE

*To be updated at your future dental visits*

Date Of Visit	Changes To Health History / Medication	Detail Changes Initials
1. _____	YES _____ NO _____	_____
2. _____	YES _____ NO _____	_____
3. _____	YES _____ NO _____	_____

# 5

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_  
 Former Dentist \_\_\_\_\_  
 City/State \_\_\_\_\_  
 Date of last dental visit \_\_\_\_\_  
 Date of last dental X-rays \_\_\_\_\_

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

Are you satisfied with the appearance of your teeth?  Yes  No  
 Bad Breath  Yes  No  
 Bleeding Gums  Yes  No  
 Blisters on lips or mouth  Yes  No  
 Burning sensation on tongue  Yes  No  
 Chew on one side of mouth  Yes  No  
 Cigarette, pipe, or cigar smoking  Yes  No  
 Clicking or popping jaw  Yes  No  
 Dry Mouth  Yes  No

Fingernail Biting  Yes  No  
 Food collection between the teeth  Yes  No  
 Grinding Teeth  Yes  No  
 Gums swollen or tender  Yes  No  
 Jaw pain or tiredness  Yes  No  
 Lip or cheek biting  Yes  No  
 Loose teeth or broken fillings  Yes  No  
 Mouth Breathing  Yes  No  
 Mouth pain, brushing  Yes  No  
 Orthodontic Treatment  Yes  No  
 Pain around ear  Yes  No  
 Periodontal Treatment  Yes  No  
 Sensitivity to cold  Yes  No  
 Sensitivity to heat  Yes  No  
 Sensitivity when biting  Yes  No  
 Sore or growths in your mouth  Yes  No  
 Would you like to keep your natural teeth?  Yes  No  
 How often do you floss? \_\_\_\_\_  
 How often do you brush? \_\_\_\_\_

# 6

## HEALTH HISTORY

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

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

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

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

## ALLERGIES

Aspirin  Local Anesthetic  
 Barbiturates (Sleeping pills)  Penicillin  
 Codeine  Sulfa  
 Iodine  Other \_\_\_\_\_  
 Latex  No Known Allergies