

REGISTRATION
(please print)

Shrewsbury & Associates, PSC
Ronald G. Shrewsbury, DMD

PATIENT INFORMATION

DATE: _____

Name _____ Social Security#: _____
(last) (first) (MI)

Address: _____ Phone: _____

Email Address: _____ Cell Phone: _____

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 _____

Relation to Patient _____ Last Name _____ Birthdate _____ First Name _____ Social Security# _____ Initial _____

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 and Associates** 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

- | | | |
|--|---|--|
| <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 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:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Arthritis, rheumatism | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Swelling feet/ankles |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Venereal disease |

MEDICATIONS

List medications you are currently taking: _____

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates(sleeping pills) | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Other |
| <input type="checkbox"/> Local Anesthetic | _____ |

ALLERGIES

Pharmacy Name _____ Phone _____

SIGNATURE

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 _____