KEITH W. MATHENY, D.D.S.
FAMILY DENTISTRY

PATIENT REGISTRATION

Date: _____/_____/_____

Patient Name_____ Birth date_____

Address_____ Home Phone_____

City, State _____Zip Code_____ Work Phone _____

Patient SS#_____ Cell Phone_____

Patient Employer _____ Length of Employment _____

Spouse's Name _____ Birth date _____

Spouse's Employer _____ Length of Employment _____

Responsible Party For Payment Of Services If Other Than The Patient:

Name _____ Birth date _____

Address_____ Home Phone _____

City, State _____Zip Code _____ Work Phone _____

Relationship to the patient _____

Referred by_____ (We appreciate new patients and would like to thank them for referring you.)

Dental Insurance

Primary Insurance _____

Address _____ Phone _____

City, State _____ Zip _____

Subscriber Name: _____

SS# or ID# _____ Birth date _____

Employer _____ Group# _____

Secondary Insurance _____

Address _____ Phone _____

City, State _____ Zip _____

Subscriber Name: _____

SS# or ID# _____Birth date _____

Employer _____ Group#_____

ASSIGNMENT & RELEASE: I hereby authorize my insurance benefits to be paid directly to the dentist. I authorize the release of such information as required for insurance reimbursement. I understand that I am financially responsible for any balance due and that payment from my insurance carrier is subject to my deductible, yearly maximum and eligibility at the time the services are rendered. Furthermore, I understand that a 1% monthly interest rate is assessed on all amounts due over 60 days. In the event of default, I promise to pay all legal costs and reasonable attorney fees as may be required to effect collection of this note.

Date Signature of Patient, Parent or Responsible Party

The undersigned hereby authorizes doctor to take radiographs, study models, or other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the patient's treatment. I also understand the use of dental anesthetic agents embodies a certain risk.

Date Signature of Patient, Parent or Responsible Party

DENTAL HISTORY

1. What is your main reason for seeking dental care today? _____

2. When was your last full mouth series X-rays or panoramic X-ray taken? _____

3. Last dentist name and phone #_____

4. Have you last any teeth? _____ Why? _____

5. Have they ever been replace by: A fixed bridge Removable partial Denture Implants

6. Are your teeth sensitive to: Heat Cold Sweets Sour Chewing

7. Have you had your teeth straightened? (braces, retainers) _____ When? _____

8. How often do you brush your teeth? _____ What type of toothbrush? Hard Med Soft

9. Do you use: Dental Floss _____ How Often? _____ Between-the-teeth simulator Water jet Sonicare

10. Do you have bleeding gums? _____ Have you ever been treated for gum disease? _____ What was done? _____

    When? _____ Do you feel you may have bad breath at times? _____ Unpleasant taste in mouth? _____

11. Does food wedge between your teeth? _____ Where? _____

12. Do you grind or clench your teeth? _____ When? _____ Any pain in and around your ears? _____

    Do you hear popping, clicking or snapping noises when you chew? _____ Which side? _____ Ever sought treatment? _____

13. Are you aware of any swelling or lump in your mouth? _____

14. Do you smoke or use tobacco products? _____

MEDICAL HISTORY

1. Are you taking any medications? _____ If so, please list them and what they are for _____

   _____

2. Physicians name and phone #: _____ Date of last physical exam _____

3. Do you or have you had any of the following? Please indicate with a check mark.

YES	NO		YES	NO		YES	NO		YES	NO	
[]	[]	Heart Attack	[]	[]	If yes, please list	[]	[]	Malignancies	[]	[]	Ulcer
[]	[]	High Blood Pressure	[]	[]	_____	[]	[]	Psychiatric care	[]	[]	AIDS/ HIV (circle one)
[]	[]	Scarlet fever	[]	[]	Other Allergies to	[]	[]	Epilepsy	[]	[]	Excessive bleeding
[]	[]	Circulatory problems	[]	[]	_____	[]	[]	Stroke	[]	[]	Diabetes/ take insulin
[]	[]	Nervous problems	[]	[]	Anemia	[]	[]	Tuberculosis	[]	[]	Hepatitis
[]	[]	Rheumatic Fever	[]	[]	Arthritis / Rheumatism	[]	[]	Venereal Disease	[]	[]	Hysterectomy
[]	[]	Allergies to dental	[]	[]	Asthma	[]	[]	Liver disorders	[]	[]	Organ transplants
[]	[]	Anesthetics (novocaine)	[]	[]	Sinus problems	[]	[]	Kidney disorders	[]	[]	Taken (previously taken) Fen
[]	[]	Allergies to medicines	[]	[]	Tonsillitis	[]	[]	Head Traumas	[]	[]	Fen or Redux Physician consulted?
[]	[]	Or drugs	[]	[]	Heart murmur/ Premedicate	[]	[]	Chemotherapy	[]	[]	Artificial joints/ pins/ implants

WOMEN (4a and 4b)

4a. Are you pregnant? Yes No If yes, which trimester? _____

4b. Are you currently taking any kind of birth control? Yes No
If yes, please read and sign: Antibiotics may alter effectiveness of birth control. Signed: _____

5. Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.

   _____

6. The above information is true and correct. Signed: _____