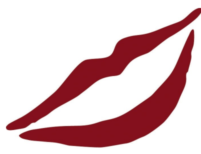


Better Bites by BUSCH DENTISTRY

DENTAL REGISTRATION AND HISTORY

Date________________________
Patient_______________________________________ **Prefer to be addressed as**______________
Address_______________________________________ **City**____________ **State**______ **Zip**________
Sex____**M**____**F** **Birth Date**_________________ **Age**_____________ **SS#**___________________
Occupation__________________________________ **Employer**__________________________________
Employer Address___________________________ **City**_____________ **State**_____ **Zip**_________
_____**Single** _____**Married** _____**Widowed** _____**Separated** _____**Divorced**
Spouse's Name______________________________
Occupation__________________________________ **Employer**__________________________________

Whom May We Thank For Referring You?____

Home Phone#_______________________________ **Cell Phone#**____________________________
E-Mail____________________________________ **Work Phone#**____________________________
In Case of an Emergency, Contact___________________________ **Relationship**__________
Home Phone#_______________________________ **Work Phone#**_____________________________

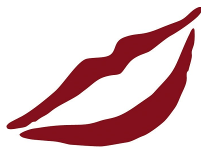
Reason For Today's Visit____
Former Dentist_____________________________ **City/State**______________________________
Last Dental Visit___________________________ **Date of Last Dental X-rays**_____________

Please Answer All of the Following Questions:

How Often Do You Brush? _________________ **How Often do You Floss?** ______________
Date of Last Dental Cleaning________________ **Toothpaste Brand**______________________
Have You Had Periodontal (Gum) Treatment? ___________ **Doctor**______________________
Have You Had Orthodontic Treatment (Braces)? _________ **Doctor**______________________
Are you Happy with the Appearance of Your Teeth? _____________________________________

Bad Breath	__Yes __No	**Loose Teeth**	__Yes __No
Dry Mouth	__Yes __No	**Broken Fillings**	__Yes __No
Growths in Mouth	__Yes __No	**Chew on One Side**	__Yes __No
Blisters on Lips/Mouth	__Yes __No	**Clenching Habit**	__Yes __No
Jaw Pain/Tiredness	__Yes __No	**Grinding Habit**	__Yes __No
Clicking/Popping Jaw	__Yes __No	**Pain Around Your Ears**	__Yes __No
Sensitivity to Hot	__Yes __No	**Fingernail Biting**	__Yes __No
Sensitivity to Cold	__Yes __No	**Burning Tongue**	__Yes __No
Sensitivity to Sweets	__Yes __No	**Bleeding Gums**	__Yes __No
Sensitivity to Brushing	__Yes __No	**Gums Swollen/Tender**	__Yes __No
Sensitivity to Biting	__Yes __No	**Lip/Cheek Biting**	__Yes __No
Food Collection Between Teeth	__Yes __No	**Mouth Breathing**	__Yes __No
Do You Smoke?	__Yes __No		

Circle All That Apply: Cigarette Cigar Pipe Vape Chewing Tobacco Recreational Drugs



Better Bites
by BUSCH
DENTISTRY

Health History

Patient____ **Date**________________

Primary Physician ________________________ **Physician's Phone #**__________________

Condition	Yes	No
AIDS	__Yes	__No
Anemia	__Yes	__No
Arthritis	__Yes	__No
Artificial Heart Valves	__Yes	__No
Artificial Joints	__Yes	__No
Asthma	__Yes	__No
Back Problems	__Yes	__No
Bleeding Abnormally (With extractions or Surgery)	__Yes	__No
Blood Disease	__Yes	__No
Cancer	__Yes	__No
If Cancer, Neck or Head Region	__Yes	__No
Chemical Dependency	__Yes	__No
Chemotherapy	__Yes	__No
Chiropractor	__Yes	__No
Circulatory Problems	__Yes	__No
Congenital Heart Lesions	__Yes	__No
Cortisone Treatment	__Yes	__No
Persistent Cough	__Yes	__No
Diabetes	__Yes	__No
Emphysema	__Yes	__No
Epilepsy	__Yes	__No
Fainting/Dizziness	__Yes	__No
Glaucoma	__Yes	__No
Headaches	__Yes	__No
Heart Murmur	__Yes	__No
Heart Problems	__Yes	__No
Hepatitis Type ____	__Yes	__No
Herpes	__Yes	__No
High Blood Pressure	__Yes	__No
Jaundice	__Yes	__No
Jaw Pain	__Yes	__No
Kidney Disease	__Yes	__No
Liver Disease	__Yes	__No
Low Blood Pressure	__Yes	__No
Mitral Valve Prolapse	__Yes	__No
Nervous Problems	__Yes	__No
Pacemaker	__Yes	__No
Psychiatric Care	__Yes	__No
Radiation Treatment	__Yes	__No
Respiratory Disease	__Yes	__No
Rheumatic/Scarlet Fever	__Yes	__No
Shingles	__Yes	__No
Shortness of Breath	__Yes	__No
Sinus Trouble	__Yes	__No
Skin Rash	__Yes	__No
Special Diet	__Yes	__No
Stroke	__Yes	__No
Swollen Feet/Ankles	__Yes	__No
Swollen Neck Glands	__Yes	__No
Thyroid Problems	__Yes	__No
Tonsillitis	__Yes	__No
Tuberculosis	__Yes	__No
Tumor on Head or Neck	__Yes	__No
Ulcer	__Yes	__No
Venereal Disease	__Yes	__No
Weight Loss, Unexplained	__Yes	__No

Do You Wear Contact Lenses? __Yes __No

<u>Sleep</u>: **Do You Snore?** __Yes __No
Do You Wear a CPAP? __Yes __No
Have You Had a Sleep Test? __Yes __No
Do You Wear a Nightguard? __Yes __No

<u>Women</u>: **Are You Pregnant?** __Yes __No **Due Date**______________ **Nursing?** __Yes __No
Taking Birth Control Pills? __Yes __No

Medications:

List any medications you are taking including over the counter
Herbs, vitamins, and supplements along with their usage

____

____

____

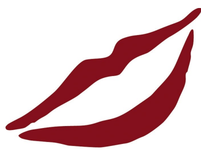
____

____

____

Allergies:

__Aspirin
__ Barbiturates (Sleeping Pills)
__ Codeine
__ Iodine
__ Latex
__ Local Anesthetic
__ Penicillin
__ Sulfa
__Other ________________________________



Dental Insurance and Account Information

Who is responsible for this account? ____

Relationship to Patient ____

Billing Address (If different than listed on registration)____________________________

City ______________________________ **State** _________ **Zip** ____________________

Payment is due at time of treatment. We accept the following methods of payment: Visa, MC, Amex, Discover, Cash and Local Checks.
***Please note there will be additional fees associated with returned checks.**

Insurance Company ____

Insurance Address____

City ______________________________ **State** _________ **Zip** ____________________

Insurance Phone # _____________________ **Group #** __________________________

Subscriber's Name________________________ **Birthdate**______________________

Employer______________________________ **ID#** ____________________________

Relationship to Patient ____

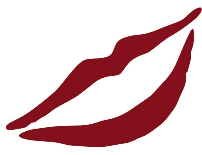
<u>Assignment and Release</u>

I, the undersigned certify that I (or my dependent) have insurance coverage with ___________________________________ (Insurance Company) and assign directly to Dr. Edward B. Busch 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.

____
Print

____
Signature

____
Date



Consent To HIPPA & Treatment

This information has been Completed by the patient or the patient's legally authorized representative/guardian:

I consent to dental treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand that this practice will share patient health information according to federal and state law for treatment, payment and operations.

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by my dentist to help determine the appropriate and healthful dental treatment. If there is any change to my medical status, I will inform the dentist.

If utilizing dental insurance, I authorize the insurance provider to pay this practice for services rendered. I understand that the patient is responsible for all charges incurred regardless of the patient's insurance status. The patient agrees to pay for services as treatment is performed.

____

Print

____

Signature

____

Date