



Robert J. Asp, DDS
& Associates

Live Life Smiling!

Dental Registration and History

Patient Information

Date _____

Social Security # _____

Patient Name (Last, First, MI) _____

Address _____

City _____

State _____ Zip _____

Sex Male Female Age _____

Birthdate _____

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Married Single Separated Divorced

Widowed Minor Partnered for _____ years

Spouse's Name _____

Spouse's Birthdate _____

Spouse's Social Security # _____

Spouse's Employer _____

Contact Information

Home (_____) _____

Work (_____) _____ EXT _____

Cell Phone (_____) _____

Email _____

On a scale of 1-5, please rank your preferred method of contact.

Email _____ Text Message _____

Home # _____ Cell # _____ Work # _____

This office may leave messages on voice mail, an answering machine, or with a family member in regards to my or my family's appointments and necessary information
(Please initial) _____

Emergency Contact

Name _____

Relationship _____

Home (_____) _____

Work or Cell Phone (_____) _____

How Did You Hear About Us?

Referred by _____

Website Newspaper _____

Billboard Facebook Word of Mouth

Other _____

Dental Insurance

Subscriber's Name _____

Relationship to patient _____

Insurance Co. _____

Group # _____

Is patient covered under additional insurance? Y/N

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Assignment and Release

I certify that I, and/or my dependent(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. 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 dentist 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. I authorize the use of photos for marketing or educational purposes in accordance with HIPPA regulations. This consent will end when my current treatment plan is completed or one year from the date signed above.

Signature of Patient, Parent, Guardian or Personal Rep.

Please Print Name of Patient, Parent, Guardian, or Personal Rep

Medical History

Are you in good health? _____

Are you now under the care of a physician? If yes, what are you being treated for? _____

Physician's Name _____

Address _____

Phone (_____) _____

Date of Last Visit _____

Has a doctor or dentist recommended that you take antibiotics prior to dental treatment? _____

Have you had any serious illnesses, operations, or hospitalizations in the past 3 years? If yes, describe _____

Have you ever taken medication for osteoporosis? _____ If yes, when did you start or discontinue taking? _____

Have you ever taken any of the group of drugs referred to as "fen-phen"? _____

Do you currently use tobacco? If yes, describe _____

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	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Feet/Ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Abnormally	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumor of Head/Neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Cortisone Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	For Women:		
Cough, persistent or bloody	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Due Date _____		
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you nursing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Taking birth control?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting or Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Please list any medications you are taking (including over-the-counter): _____

Pharmacy Name _____

Please mark if you have any of the following allergies:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Barbiturates
<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Other _____

Pharmacy Phone (_____) _____

Dental History

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

How often do you brush? _____

How often do you floss? _____

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

Bad Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Gums	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blisters on lips/mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chew on one side of mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cigarette, pipe, cigar smoking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Food collection between teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Foreign objects	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Grinding or clenching teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Gums swollen or tender	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Injuries to face/mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Jaw pain or tiredness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lip or cheek biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loose teeth or broken fillings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mouth breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mouth pain, brushing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Orthodontic treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain around ear	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Periodontal treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitivity to cold	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitivity to heat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitivity to sweets	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitivity when biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sores or growths on mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No