Rosalyn L Burke, DDS PC

REGISTRATION AND HISTORY

PATIENT INFORMATION

Date_____

SSN_____

Patient Name (last,first)_____

_____

Address_____

City_____

State_____ Zip Code_____

E-mail_____

Sex ☐M ☐F Birthdate_____Age____

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Domestic Partner

Occupation_____

Employer/School_____

Employer/School Address_____

_____

Employer/School Phone_____

Spouse's Name_____

Spouse's Birthdate_____

Spouse's SSN_____

Spouse's Employer_____

Whom may we thank for referring you to Dr. Burke?

_____

DENTAL INSURANCE

Who is responsible for this account?_____

Relationship to patient_____

Insurance Company_____

ID #_____ Group #_____

Is patient covered by additional insurance? ☐Yes ☐No

If YES, please answer the following for secondary insurance coverage:

Subscriber's Name_____

Birthdate_____SSN_____

Relationship to patient_____

Insurance Company_____

ID #_____ Group #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with (insurance company)_____ and assign directly to Dr. Rosalyn Burke 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 and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient, Parent, Guardian, or Legal Representative

_____

Please print Patient, Parent, Guardian, or Legal Representative name

_____ _____

Date Relationship to Patient

PHONE NUMBERS

Home_____ Cell_____ Work_____

Best Number and Time to reach you_____

Do we have your permission to discuss financial matters, as well as treatment, with you on your cell phone? ☐Yes ☐No

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household)

Name_____ Relationship_____

Primary Phone_____ Secondary_____

DENTAL HISTORY

Reason for today's visit_____

Former Dentist_____

City/State_____

Date of last visit_____

Please indicate "yes" or "no" for the following

Bad Breath	☐Yes ☐No
Bleeding gums	☐Yes ☐No
Blisters on lips/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 teeth	☐Yes ☐No
Foreign objects	☐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 to sweets	☐Yes ☐No
Sensitivity when biting	☐Yes ☐No
Sores or growths in mouth	☐Yes ☐No
Tobacco Use	☐Yes ☐No

How often do you floss?_____

How often do you brush?_____

Do you have any **dislikes** or **preferences** when it comes to YOUR dental treatment? ☐Yes ☐No

If Yes, please explain_____

_____

_____

_____

HEALTH HISTORY

Physician's Name_____ Date of last visit_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Boniva, Actonel ☐Yes ☐No
Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine) ☐Yes ☐No

Please indicate "**yes**" or "**no**" if you have had any of the following:

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

WOMEN:

Are you pregnant	☐Yes☐No	Taking Birth Control	☐Yes☐No	Are you nursing	☐Yes☐No

If yes, when are you due_____

MEDICATIONS

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

_____

_____

_____

_____

Pharmacy Name_____

Phone_____

ALLERGIES

☐Asprin ☐Local Anesthetic

☐Barbiturates (Sleeping Pills) ☐Penicillin

☐Codeine ☐Sulfa

☐Iodine ☐Other_____

☐Latex _____

_____

☐NO KNOWN ALLERGIES

PATIENT SIGNATURE_____ DATE_____