ANTOINETTE MARIE TAUK, D.D.S., L.L.C.

PATIENT REGISTRATION AND MEDICAL HISTORY FORM

CONTACT INFORMATION

Date _____ (PLEASE PRINT) Home Phone _____

Email Address _____ Cell Phone _____

Preferred Contact Method ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Patient Name_____

Last Name *First Name* *Initial* *Preferred Name*

Street Address _____ City _____ State _____ Zip _____

Sex: ☐M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐Divorced

Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Parent/Spouse Social Security # _____

Name of Primary Dental Insurance Company _____ Group # _____

Are you covered by additional insurance? ◯ Yes ◯ No If yes, name of secondary insurance _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Physician's Address _____ Phone _____

Please mark "Yes" or "No" to indicate if you have any of the following:

AIDS	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No	Respiratory Disease	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Fainting/Dizziness	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Arthritis/Rheumatism	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valves	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Shortness of Breath	◯ Yes ◯ No
Artificial Joints	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Heart Problems	◯ Yes ◯ No	Skin Rash	◯ Yes ◯ No
Back Problems	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Special Diet	◯ Yes ◯ No
Bleeding Abnormally,		Type _____		Stroke	◯ Yes ◯ No
With extraction/surgery	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Swelling of Feet	
Blood Disease	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	or Ankles	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Swollen Neck Glands	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	HIV Positive	◯ Yes ◯ No	Thyroid Problems	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Jaundice	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Circulatory Problems	◯ Yes ◯ No	Jaw Pain	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Congenital Heart Lesions	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No	Tumor or Growth	
Cortisone Treatments	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	On Head or Neck	◯ Yes ◯ No
Cough, persistent		Low Blood Pressure	◯ Yes ◯ No	Ulcer	◯ Yes ◯ No
Or bloody	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Nervous Problems	◯ Yes ◯ No	Weight Loss,	
Emphysema	◯ Yes ◯ No	Pacemaker	◯ Yes ◯ No	Unexplained	◯ Yes ◯ No
Do you wear		Psychiatric Care	◯ Yes ◯ No		
Contact lenses?	◯ Yes ◯ No	Radiation Treatment	◯ Yes ◯ No		

Do You Smoke (Cigarette, Pipe or Cigar Smoking)? ◯ Yes ◯ No

Do You Use Recreational Drugs? ◯ Yes ◯ No

For Women Only:

Are you Pregnant? ◯ Yes ◯ No

Due Date _____

Are You Nursing? ◯ Yes ◯ No

MEDICATIONS

Please list all medications you are currently taking:

_____

_____

_____

_____

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Iodine
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other

_____

Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address _____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist's Name _____ Phone _____

Address _____

Date of Last Dental Visit _____ Date of Last Dental X-Rays _____

How Often Do You Floss? _____ How Often Do You Brush? _____

Please mark "Yes" or "No" to indicate if you have any of the following:

Bad Breath	○ Yes ○ No	Loose Teeth or Broken Fillings	○ Yes ○ No
Bleeding Gums	○ Yes ○ No	Mouth Breathing	○ Yes ○ No
Blisters on Lips or Mouth	○ Yes ○ No	Mouth Pain, Brushing	○ Yes ○ No
Burning Sensation on Tongue	○ Yes ○ No	Orthodontic Treatment	○ Yes ○ No
Clicking or Popping Jaw	○ Yes ○ No	Pain Around Ear	○ Yes ○ No
Dry Mouth	○ Yes ○ No	Piercings	○ Yes ○ No
Fingernail Biting	○ Yes ○ No	Periodontal Treatment	○ Yes ○ No
Food Collection Between Teeth	○ Yes ○ No	Sensitivity to Cold	○ Yes ○ No
Grinding Teeth	○ Yes ○ No	Sensitivity to Heat	○ Yes ○ No
Gums Swollen or Tender	○ Yes ○ No	Sensitivity to Sweets	○ Yes ○ No
Jaw Pain or Tiredness	○ Yes ○ No	Sensitivity When Biting	○ Yes ○ No
Lip or Cheek Biting	○ Yes ○ No	Sores or Growths In Your Mouth	○ Yes ○ No
Other	○ Yes ○ No	_____	

NOTES:

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____

Name of Insurance Company/Companies

and assign directly to Dr. Antoinette Tauk 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 my insurance submissions whether manual or electronic.

_____ _____

Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and

Name of Minor/Child

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and the administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____

Date *Signature of Insured/Guardian*

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time treatment, unless other arrangements are made. I agree that parents/ guardians are responsible for all fees and services for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____

Date *Signature of Insured/Guardian*

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. 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. I will also agree to inform Dr. Tauk of any changes in my medical history.

_____ _____

Date *Signature*

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