K. MICHAEL RHYNE, D.D.S., P.A.

REGISTRATION & HEALTH HISTORY

Today's Date ______________

Patient's Name ______________________________ Married ______

Name of Spouse ______________________________ Single ______

Street Address ______________________________ Widowed ______

City ______________ County ______________ Divorced ______

Separated ______

State ________ Zip Code ________ Home Phone ______________

Patient's Date of Birth ____________ Male ______ Female ______

Patient Employed By ______________________ Work Phone ______________

Position Held ______________________ How Long? ______________

Spouse Employed By ______________________ Work Phone ______________

Position Held ______________________ How Long? ______________

Social Security # ______________ Spouse's Social Security # ______________

Do You Have Dental Insurance ______Yes ______ No

If So, Name of Primary Company ______________________ Group # ______________

Insurance Company Address ______________________________

Secondary Company______________________ Group # ______________

Insurance Company Address ______________________________

In Case of Emergency, Who Should Be Notified? ______________________________

Relationship to Patient ______________________ Phone Number ______________

Reason For This Visit ______________________________

Who May We Thank For Referring You? ______________________________

Payment of Professional Fees: (Please Check One)

☐ Cash or Check ☐ Visa, MasterCard, Discover, AMEX ☐ Other ______________

CONSENT: The undersigned hereby authorizes K. Michael Rhyne, D.D.S., P.A. to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Rhyne to make a thorough diagnosis of the patient's dental needs, and to use such records as appropriate to educate and inform patients regarding dental treatment. I also understand there will be a charge for broken appointments without 24-hours notice.

Signature ______________________ Date ______________

INSURANCE: I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment regardless of insurance coverage.

I hereby authorize insurance payment to K. Michael Rhyne, D.D.S., P.A., otherwise payable to me.

Signature ______________________ Date ______________

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone.

DENTAL HISTORY

How LONG SINCE you have seen a Dentist? ____________

Last COMPLETE Dental Exam, Date: ____________

Last FULL MOUTH X-RAYS, DATE: ____________
(Machine that rotates around your head, or 18 small films.)

Are you having PROBLEMS now? ____________

WHAT? ____________

	YES	NO
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partial or full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Have you had BAD dental experiences in the past?	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you in discomfort now?	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES or NECK PAINS?	☐	☐
Do you have LOOSE, TIPPED, or SHIFTING teeth? (circle)	☐	☐
Have you worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you have problems with teeth/fillings BREAKING?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Would you like us to help you learn proper methods of Home Care, so you can stop dental problems in your mouth?	☐	☐

Name of previous Dentist: ____________

City: ____________ State: ____________

How do you feel about your teeth? ____________

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment:

FEAR of pain #________

COST of treatment #________

LACK of concern #________

MISSING work time #________

MEDICAL HISTORY

Do you have any CURRENT HEALTH PROBLEMS?

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Are you under a PHYSICIAN'S CARE now? ________
For What? ____________

Are you currently taking any medication? ________
If yes, what? ____________

Circle any of the following which you have had or have at present:

Heart Failure	A.I.D.S.	Bruise Easily
Heart Disease or Attack	Hepatitis A (infectious)	Emphysema
Angina Pectoris	Hepatitis B (serum)	Tuberculosis (TB)
High Blood Pressure	Liver Disease	Asthma
Heart Murmur	Yellow Jaundice	Hay Fever
Rheumatic Fever	Blood Transfusion	Sinus Trouble
Congenital Heart Lesions	Drug Addiction	Allergies or Hives
Scarlet Fever	Hemophilia	Diabetes
Artificial Heart Valve	Fever Blisters	Thyroid Disease
Heart Pacemaker	Epilepsy or Seizures	Heart Surgery
X-ray or Cobalt Treatment	Fainting or Dizzy Spells	Arthritis
Artificial Joints (Hip, Knee)	Nervousness	Rheumatism
Anemia	Psychiatric Treatment	Cortisone Medicine
Stroke	Sickle Cell Disease	Pain in Jaw Joints
Kidney Trouble	Glaucoma	Ulcers
Chemotherapy (Cancer, Leukemia)		Cosmetic Surgery
Venereal Disease (Syphilis, Gonorrhea, etc.)		

Are you allergic or have you reacted adversely to any of the following medications?

Aspirin	Percodan	Erythromycin
Darvon	Local Anesthetic	Valium
Nitrous Oxide	Codeine	Penicillin

Are you aware of being allergic to any other medications or substances? If so, please list: ____________

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FAMILY PHYSICIAN ____________

PHONE # ____________

Is there any other Medical or Dental information that you feel I should know about?

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