DEAN J. KOKINIAS, D.D.S.
Patient Registration and Health History

Patient Information *(confidential)*

Date _____

Name _____ **Sex** ☐M ☐F **Birthdate** _____

Check One Box ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed

Street Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Patient SSN #** _____ -- _____ -- _____

Email address: _____

Name of Person Responsible for this Account _____ **Relationship to Patient** _____

Address (if different) _____ **City** _____ **State** _____ **Zip** _____

Phone # (home) _____ **(cell)** _____ **SSN #** _____ -- _____ -- _____

Spouse/Guardian's Date of Birth _____ **Driver's License#**_____

Person to contact in case of emergency? _____ **Phone** _____

Whom may we thank for referring you? _____

If internet, which source? ☐ **Dr. Kokinias website** ☐**Yelp** ☐**Google** ☐ **Yellow Pages** ☐ **Other** _____

Insurance

Name of Primary Dental Insurance Co._____ **Policy #** _____

Insured's Name _____ **Employer** _____ **Grp#** _____

Dental History

Date of last Dental Exam _____ **Date of Last Cleaning** _____

Do you have or have you had any of the following, please indicate with a (✓).

- ☐ **Teeth sensitive to cold, heat, sweets, or pressure**
- ☐ **Bleeding gums**
- ☐ **Teeth clenching or grinding**
- ☐ **Complications from extractions**
- ☐ **Swelling or lumps in mouth**
- ☐ **Pain around ear**
- ☐ **Clicking or popping of jaw**
- ☐ **Unfavorable dental experience**
- ☐ **Frequent blisters on lips or in mouth**
- ☐ **Orthodontic Treatment**
- ☐ **Burning of tongue**
- ☐ **Bad Breath**
- ☐ **Unpleasant taste**

Medical History

Physician's Name _____ **Office Phone** _____ **Date of last physical exam** _____

Do you have or have you had any of the following, please indicate with a (✓).

- ☐ **Allergic to medications …if so, which one(s)**_____
- ☐ **Allergic to Local Anesthetics (e.g. Novocain)** _____
- ☐ **Allergic to Latex Rubber**
- ☐ **Radiation treatments**
- ☐ **Excessive bleeding from cut or extraction**
- ☐ **High blood pressure**
- ☐ **Heart Murmur**
- ☐ **Mitral Valve Prolapsed**
- ☐ **Artificial heart valves or joints**
- ☐ **Any other heart ailments**
- ☐ **Neurological problems**
- ☐ **Ulcer or Colitis**
- ☐ **Hepatitis or liver disease**
- ☐ **Cancer**
- ☐ **Anemia or blood problems**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Hay fever or allergies in general**
- ☐ **Diabetes**
- ☐ **Kidney problems**
- ☐ **Thyroid Disorder**
- ☐ **Epilepsy**
- ☐ **Rheumatic Fever**
- ☐ **Sinus problems**
- ☐ **Respiratory Disease**
- ☐ **Stroke**
- ☐ **Tuberculosis**
- ☐ **Herpes venereal disease**
- ☐ **HIV Positive**
- ☐ **A.I.D.S**

Are you taking any medication at this time? _____ **If so, what medications?** _____

Are you under the care of a physician? _____ **For what condition?** _____

(Women only) Are you pregnant? ☐**Yes** ☐**No** **Nursing?** ☐**Yes** ☐**No** **Taking birth control pills?** ☐**Yes** ☐**No**

Is there anything else we should know about your medical history? _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature (Parent if minor) _____ **Date** _____