

DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

PAUL M. MALLOUK, D.D.S.

1319 Main Street
Delano, CA 93215

Telephone: (661) 725-9105

Date _____ Home Phone (_____) _____ Cell Phone (_____) _____

PATIENT INFORMATION

Name Last Name _____ First Name _____ Middle Initial _____	SS/HIC/Patient ID # _____
Address _____	E-mail _____
City _____	State _____ Zip _____
Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate _____	<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor
	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years
Patient Employer/School _____	Occupation _____
Employer/School Address _____	Employer/School Phone (_____) _____
Whom may we thank for referring you? _____	
In case of emergency who should be notified? _____	Phone (_____) _____

PRIMARY INSURANCE

Person Responsible for Account Last Name _____ First Name _____ Middle Initial _____	
Relation to Patient _____ Birthdate _____	Soc. Sec. # _____
Address (If different from patient's) _____	Phone (_____) _____
City _____	State _____ Zip _____
Person Responsible Employed by _____	Occupation _____
Business Address _____	Business Phone (_____) _____
Insurance Company _____	
Contract # _____ Group # _____	Subscriber # _____
Names of other dependents covered under this plan _____	

ADDITIONAL INSURANCE

Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Subscriber Name _____ Birthdate _____	Relation to Patient _____	
Address (If different from patient's) _____	Phone (_____) _____	
City _____	State _____	Zip _____
Subscriber Employed by _____	Business Phone (_____) _____	
Insurance Company _____	Soc. Sec. # _____	
Contract # _____ Group # _____	Subscriber # _____	
Names of other dependents covered under this plan _____		

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Dr. _____ Name of Insurance Company(ies)
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 doctor 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. This
consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____

Date _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Relationship to Patient _____

DENTAL HEALTH HISTORY (Confidential)

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

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

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

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

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

MEDICATIONS

List medications you are currently taking:

Pharmacy Name _____

Phone (____) _____

ALLERGIES

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Latex _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Local Anesthetic | _____ |
| <input type="checkbox"/> Penicillin | |

SIGNATURE

The above information is accurate and complete to the best of my knowledge. 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.

Date _____ Signature _____