Robert J. Yang, D.M.D., PC
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Tamuning, GU 96913
Tel: 647-8702/3 Fax: 647-8704
"We make smiles happen!"

DENTAL REGISTRATION

1 PATIENT INFORMATION

Date: ____________________

Patient: ________________________________

Mailing Address: ________________________________

City/State/Zip: ________________________________

Sex: ☐ Female ☐ Male Age: _____ Birthdate: ___________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married

Patient SS No: ________________________________

Occupation: ________________________________

Employer: ________________________________

Employer Address: ________________________________

Spouse's Name: ________________________________

Spouse's Employer: ________________________________

Whom may we thank for referring you?

____

2 RESPONSIBLE PARTY

Name of person responsible for the account:

____

Relationship to Patient: ________________________________

3 INSURANCE INFORMATIO[N]

Insurance Company: ________________________________

Subscriber's Name: ________________________________

Relationship to Patient: ________________________________

Birthdate: _______________ SS No: _______________

Group/ID No: ________________________________

Do you have any additional dental insurance? ☐ Yes ☐ N[o]

Insurance Company: ________________________________

Subscriber's Name: ________________________________

Relationship to Patient: ________________________________

Birthdate: _______________ SS No: _______________

Group/ID No: ________________________________

4 CONTACT INFORMATION

Home: _______________ Work: _______________

Cell: _______________ Other: _______________

Email Address: ________________________________

What is the best way to contact you?

☐ Home ☐ Cell ☐ Work ☐ Email

EMERGENCY CONTACT

Name: ________________________________

Relationship to Patient: ________________________________

Home: _______________ Cell/Work: _______________

Name: ________________________________

Relationship to Patient: ________________________________

Home: _______________ Cell/Work: _______________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ________________________ and assign directly to Robert J. Yang, D.M.D., PC 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

________________________ ________________
Relationship to Patient Date

5 DENTAL HISTORY

Reason for today's visit: ☐ Cleaning ☐ Toothache ☐ Exam

Area of concern: ☐ Upper Right ☐ Lower Right

☐ Upper Left ☐ Lower Left ☐ Upper Front ☐ Lower Front

Name of former dentist: ________________________________

Name of former dental clinic: ________________________________

Date of last dental visit: ________________________________

Please check appropriate box:

☐ Bleeding gums ☐ Gums swollen/tender

☐ Blisters on lips/mouth ☐ Mouth pain when brushing

☐ Clicking/popping jaw ☐ Sensitivity to cold

☐ Food between teeth ☐ Sensitivity to heat

☐ Grinding teeth ☐ Sensitivity when biting

HEALTH HISTORY

Physician's Name: ______________________ Date of last visit: __________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition		Condition		Condition	
AIDS	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis Type ___	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swelling of feet or ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Tonsilitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No		
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapsed	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Weight Loss, unexlplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Psychiatric	☐ Yes ☐ No	Women:	
Epilepsy	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	Are you pregnant? Due Date: ______	☐ Yes ☐ No
Do you wear contact lenses?	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No	Are you nursing?	☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No

List medications you are currently taking:

____

____

____

Pharmacy Name: ______________________

Phone No: ______________________

Do you have any allergies to medications? ☐ Yes ☐ No

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other: ______________

Patient's Signature ______________________ Date: __________

Doctor's Signature ______________________ Date: __________

Assistant's Initial: ______________

Medical History Update (To be filled out on your next visit)

Has there been any changes in your health since your last dental appointment? ☐ Yes ☐ No

If Yes, for what conditions? ______________________

Are you taking any new medications? ☐ Yes ☐ No If so, what: ______________________

Patient's Signature ______________________ Date: __________

Doctor's Signature ______________________ Date: __________

Assistant's Initial: ______________ Chart No: __________