

DENTAL
REGISTRATION
AND HISTORY

DEBORAH P. KILGORE, D.D.S.

1312 Commerce Drive
New Bern, NC 28562
Telephone: (252) 637 - 1919

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

Patient Information

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-Mail _____

City _____ State _____ ZIP _____

Sex M F Age ____ Birthday _____ Married Widowed Single Minor
 Separated Divorced 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 _____ SSN _____

Address (If different from patients) _____ 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? Yes No

Subscriber Nume _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ ZIP _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ SSN _____

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
Name of Insurance Company(ies)
directly to Dr. _____ all insurance benefits, if any, otherwise payable to my 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 my use my health care informtion 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 of 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

- | | | |
|-------------------------------|--------------------------------|--------------------------------|
| Bad breath | GrindingTeeth | Sensitivity to hot |
| Bleeding Gums | Loose teeth or broken fillings | Sensitivity to sweets |
| Clicking or popping jaw | Periodontal treatment | Sensitivity when biting |
| Food collection between teeth | Sensitivity to cold | 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? Yes No 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 the 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 _____