Christopher T. Bart, D.M.D., Inc.
General & Certified Lumineers® Dentist
Providing Family and Cosmetic Dental Services

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Mobile #: _____ Work #: _____

Email Address: _____

Emergency Contact: _____ Relationship: _____

Home #: _____ Work #: _____

Date of Birth: _____ Sex: ❑ Male ❑ Female Age: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Social Security #: _____

Employer: _____ Occupation: _____

Employer Address: _____

Spouse's Name: _____ Spouse's SS#: _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Company: _____

Group #: _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name: _____

Date of Birth: _____ Social Security #: _____

Relationship to Patient: _____

Insurance Company: _____ Group #: _____

ASSIGNMENT AND RELEASE

I, undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Christopher Bart 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 for 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 Date

5153 Mahoning Ave. • Warren, OH 44483 • Phone: 330.847.7333 • doctor@christopherbart.com • www.christopherbart.com

DENTAL HISTORY

Reason for today's visit: _____ Former Dentist: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

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

YES	NO	CONDITION	YES	NO	CONDITION	YES	NO	CONDITION
❑	❑	Bad Breath	❑	❑	Bleeding Gums	❑	❑	Blisters on Mouth or Lips
❑	❑	Burning Sensation on Tongue	❑	❑	Chew on One Side of Mouth	❑	❑	Cigarette, Pipe or Cigar Smoking
❑	❑	Clicking or Popping Jaw						
❑	❑	Dry Mouth	❑	❑	Fingernail Biting	❑	❑	Food Collection Between Teeth
❑	❑	Foreign Objects						
❑	❑	Grinding Teeth	❑	❑	Gums Swollen or Tender	❑	❑	Jaw Pain or Tenderness
❑	❑	Lip or Cheek Biting	❑	❑	Loose Teeth or Broken Fillings	❑	❑	Mouth Breathing
❑	❑	Mouth Pain, Brushing				❑	❑	Orthodontic Treatment
❑	❑	Pain Around Ear	❑	❑	Periodontal Treatment	❑	❑	Sensitivity to Cold
❑	❑	Sensitivity to Heat	❑	❑	Sensitivity to Sweets	❑	❑	Sores or Growths in Mouth
❑	❑	Cancer	❑	❑	Jaundice			
❑	❑	Teeth Whitening						

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

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::

YES	NO	CONDITION	YES	NO	CONDITION	YES	NO	CONDITION
❑	❑	AIDS	❑	❑	Fainting or Dizziness	❑	❑	Psychiatric Care
❑	❑	Anemia	❑	❑	Glaucoma	❑	❑	Radiation Treatment
❑	❑	Arthritis, Rheumatism	❑	❑	Headaches	❑	❑	Rheumatic fever
❑	❑	Artificial Heart Valves	❑	❑	Heart Murmur	❑	❑	Scarlet Fever
❑	❑	Artificial Joints	❑	❑	Heart Problems	❑	❑	Shortness of Breath
❑	❑	Asthma	❑	❑	Hepatitis	❑	❑	Sinus Trouble
❑	❑	Back Problems			Type: _____	❑	❑	Skin Rash
❑	❑	Bleeding Abnormally, Extractions or Surgery	❑	❑	Herpes	❑	❑	Special Diet
			❑	❑	High Blood Pressure	❑	❑	Stroke
❑	❑	Blood Disease	❑	❑	HIV Positive	❑	❑	Swelling of Feet or Ankles
❑	❑	Cancer	❑	❑	Jaundice	❑	❑	Swollen Neck Glands
❑	❑	Chemical Dependency	❑	❑	Jaw Pain	❑	❑	Thyroid Problems
❑	❑	Chemotherapy	❑	❑	Kidney Disease	❑	❑	Tonsillitis
❑	❑	Circulatory Problems	❑	❑	Liver Disease	❑	❑	Tuberculosis
❑	❑	Congenital Heart Lesions	❑	❑	Low Blood Pressure	❑	❑	Tumor or Growth on Head or Neck
❑	❑	Cortisone Treatments	❑	❑	Mitral Valve Prolapse			
❑	❑	Cough, Persistent or Bloody	❑	❑	Nervous Problems	❑	❑	Ulcer
❑	❑	Diabetes	❑	❑	Pacemaker	❑	❑	Venereal Disease
❑	❑	Emphysema	❑	❑	Are You Pregnant?	❑	❑	Unexplained Weight Loss
❑	❑	Do You Wear Contact Lenses?			Due Date: _____			
❑	❑	Epilepsy	❑	❑	Are You Nursing?			

List medications you are currently taking: _____

_____

Any allergies to the following? ❑ Aspirin ❑ Barbiturates (Sleeping Pills) ❑ Codeine ❑ Iodine ❑ Latex ❑ Local Anesthetic ❑ Penicillin ❑ Sulfa ❑ Other _____

Please fill-out entire form and bring to your first appointment with Dr. Bart

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