David L. Traub, DMD
Comprehensive Esthetic Dentistry

Patient Registration

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Name ____ Name prefer to be called: __________
Address ______________________________ City/State ______________________ Zip __________
Employer ____________________________ Occupation _________________ Lic.# __________
Home Phone __________________ Business Phone ________________ Soc. Sec # ___________
Email Address _______________________________ Cell Phone _________________________
Birthdate ______________ Age __________ Sex ________ Marital Status (circle one): M S W D
In event of an emergency please contact ______________________ Phone _______________
Who can we thank for telling you about our office? ___________________________________

Person Responsible for Payment of Account (or person with insurance)

Name ______________________________ Relationship to patient ________________________
Address ______________________________ City/State ________________________ Zip __________
Employer ____________________________ Occupation __________________________________
Employer address ____
Home Phone __________________ Business Phone ________________ Extension _____________
Birthdate ______________________ Sex _____________ Soc. Sec# __________________________

Dental Insurance Information

Primary Insurance company ____________________________ Employer ___________________
Subscriber's Name _____________________________________ Soc. Sec. # _________________
Group Number ____ I.D.# _______________________
Patient's relationship to subscriber: ...... Self........ Spouse .... Child

I understand that insurance coverage is a contract between myself and the insurance company and that the doctor makes all treatment recommendations based upon the best interests of the patient and not the availability of insurance coverage. The doctor and staff make no guarantees whatsoever regarding insurance reimbursements; if my insurance company fails to pay Dr. Traub, I will be responsible for the full amount. I further understand that all fees will be paid in full by me at the time of treatment, unless I accept and sign this insurance assignment agreement. I understand that if there is a balance after insurance pays, I will be billed for and responsible for that amount. I understand that by signing below I agree to these terms and I authorize the release of any information necessary to process my insurance claim. I hereby authorize insurance payment to Dr. Traub. A copy of this signature is valid as the original.

Signature ____ Date __________________

TMD History

Have you ever had a problem with your TMJ (jaw joints)? .... Yes No
Have you ever had an injury to the jaw? .... Yes No
Do your jaw joints ever hurt or become tender when you chew, talk, or open wide? .... Yes No
Do you ever hear any clicks, pops, or grating sounds in your jaw joints? .... Yes No
Does your jaw ever get stuck, or locked or go "out"? .... Yes No
Do you ever have difficulty opening your jaw? .... Yes No
Do you ever have a problem with your joints when you eat or chew? .... Yes No

(**OVER**)

Medical History

Are you in good health?.. Yes No
Has there been any change in your general health in the last year?........................ Yes No
Are you under the care of a physician? .... Yes No
If so, what is the condition being treated? ________________________________
Name of physician ______________________________ Phone _______________
Have you recently been seriously ill, had operations, or been hospitalized?........... Yes No
If so, what was the illness? ____
Are you taking any medications including non prescription medications? .... Yes No
If so, please list (include herbal and dietary supplements) _______________

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Circle any of the problems you may have:

Damaged heart valve	Asthma/Hay fever	High blood pressure	Pacemaker
Heart murmur	Fainting or seizures	Chest pain	Allergy
Rheumatic heart disease	Diabetes	Kidney disease	Sinus trouble
Stroke	AIDS or HIV infection	Epilepsy	Abnormal bleeding
Heart attack	Thyroid disease	Cancer	Cochlear implant
Angina	Emphysema	Hepatitis	STD
Coronary artery disease	Arthritis	Heart defect	Joint replacement

Do you have any diseases, conditions, or problems not listed above? .... Yes No
If so, explain ____
Have you ever been told to take any medications before dental appointments? Yes No
If so, explain ____
Are you allergic to any medications or latex products? .... Yes No
Circle if you are allergic to: novocaine, local anesthetic, penicillin, antibiotics, barbiturates, sedatives, aspirin, codeine, narcotics or any other medications.
Women: Are you pregnant .... Yes No If so, what month _______________

Dental History

Have you had any serious trouble associated with past dental treatment?........................... Yes No
If so, explain____
Have you ever required sedation or nitrous oxide for dental treatment? .... Yes No
Have you ever had a removable dental appliance made for you? .... Yes No
When was the appliance last made? ____
About when was your last dental treatment? _____________ Last cleaning? _____________
Have you had a full set of x-rays in the last 3 years?.. Yes No
Are you having any dental problems at this time? .... Yes No
If so, please explain____
What is the purpose of your visit with us today? _____________________________________

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Are you pleased with the appearance of your teeth? .... Yes No
If no, please explain what bothers you ____

I certify that I have read and understand the above questions. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Parent ____ Date___________________