PATIENT REGISTRATION

TODAY'S DATE_____

Patient's Name	**Birth date**		**Age**	**Sex:** **M F**
Home Address	**City**	**State**	**Zip**	
Home Phone #	***Please Circle One:*** Single, Married, Separated, Widow		**Your Social Security Number**	
Your Employer	**Occupation**		**Work Phone #**	
Are you a full time student? ☐Yes ☐ No	*If patient is minor we need Mother & Father's Names & Birth date*			
Person responsible for account:			**YOUR Driver's License Number:**	
Name of spouse (or parent if minor)			**YOUR E-mail address**	**YOUR cell phone #**
Spouse's (or parent's) employer	**Spouse's Soc. Sec. #**		**Work phone #**	
EMERGENCY INFORMATION				
Name, Address, & Telephone of A relative not living with you:				
How did you hear about our office?				
Reason for this visit?				

DENTAL INSURANCE INFORMATION (Primary Carrier)			**If you have a dual insurance coverage, complete this for the second coverage (this office bills primary ins only)**		
Insured's name	**DOB**	**SS#**	Insured's name	DOB	SS#
Insured's employer			Insured's employer		
Insurance Co			Insurance Co		
Insurance Co Address			Insurance Co Address		
Phone #			Phone #		
Group #	**Policy #**		Group #		Local #
Is there anything other medical or dental history we should know?					
Patient Signature (or parent of child)	Date		Doctor's Signature / Office Signature		

DENTAL HISTORY

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifted teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Gum treatments
- ☐ **Required to take antibiotics prior to dental treatment**

Please share the following dates:

Your last cleaning _____/_____
Your last oral cancer screening _____/_____
Your last complete x-rays _____/_____

Name of Previous Dentist:

_____
City: _____ State: _____
Phone number: _____

What is the most important thing to you about your future smile and dental health? _____

If you could whiten your teeth for a cost anyone could afford, would you do it?

_____

Do you smoke or use chewing tobacco? How much? For how long?

_____

If you could change your smile, you would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1 -10, with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____
_____

What is the most important thing to you about your dental visit today?

_____
_____

MEDICAL HISTORY

Please check any of the following that apply to you:

- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Phen Fen (1 month +)
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Have you ever taken Bisphosphonates? (i.e. Aredia, Fosamax, Boniva)
- ☐ Other:

_____
_____
_____

For WOMEN Only

- ❑ Birth Control Pills
- ❑ Breast-feeding
- ❑ Pregnant

1-3 mos,3-6 mos,6-9mos,

Do you have an allergy to any of the following?

- ☐ Aspirin
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Codeine
- ☐ Other: _____

What medications are you taking?

_____
_____
_____
_____

Are you under a physician's care? For what?

_____

Family Physician _____ **Phone Number** _____

Patient Signature (or parent of child)	Date	Doctor's Signature/ Assistant