Patient Registration

Date:________________________________

First Name____ Last Name _______________________________Middle Initial________

Preferred Name____ E-mail____

Patient Information

Address____

City____ State_____________________________ Zip___________________

Home Phone_________________________Cell Phone________________________Work Phone_______________________ Ext_______

Birthdate___________________ Age_______ Social Security________________________Drivers License__________________________

Sex________ Marital Status__________________ Employer____________________________

Responsible Party (if someone other than the patient)

First Name__________________________________Last Name____Middle Initial_______

Address____

City____State_____________________________Zip__________________

Home Phone___________________________Cell Phone_______________________Work Phone______________________Ext_______

Birthdate________________________Age______Social Security_________________________Drivers License_____________________

In Case of Emergency Contact

Name____Relationship____________________________

Home Phone_________________________Cell Phone____________________________Work Phone_____________________Ext____

Primary Insurance Information

Name of Insured____Relationship_________________________________

Insured Social Security______________________________ Insured Birth Date___________________________

Insured ID # (usually found on dental insurance card) ____

Employer____ Group #___________________________________

Insurance Company____ Phone #______________________________

Address____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Y / N If yes explain____

Have you ever been hospitalized? Y / N ____

Have you ever had a serious neck injury? Y / N ____

Are you taking any medications, pills or drugs? Y / N ____

Do you take, or have you taken, Phen-Fen or Redux? Y / N ____

Have you ever taken Fosamax, Boniva, Actonel or any other meds containing bisphosphonates? Y / N ____________________

Are you on a special diet? Y / N____

Do you use tobacco? Y / N ____

Do you use controlled substances? Y / N ____

Women: Are you pregnant/trying to get pregnant? _______ Taking Oral contraceptives?______ Nursing?__________

Are you allergic to any of the following? Aspirin ____ Penicillin ____ Codeine ____ Acrylic ____ Metal ____ Latex ____ Local Anesthetic ____

Sulfa Drugs ______ Other:____

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

AIDS/HIV Positive	Y / N	Cortisone Medicine	Y / N	Hepatitis A	Y / N	Renal Dialysis	Y / N
Alzheimer's Disease	Y / N	Diabetes	Y / N	Hepatitis B or C	Y / N	Rheumatic Fever	Y / N
Anaphylaxis	Y / N	Drug Addiction	Y / N	Herpes (mouth)	Y / N	Rheumatism	Y / N
Anemia	Y / N	Easily Winded	Y / N	High Blood Pressure	Y / N	Scarlet Fever	Y / N
Angina	Y / N	Emphysema	Y / N	High Cholesterol	Y / N	Shingles	Y / N
Arthritis/ Gout	Y / N	Epilepsy or Seizures	Y / N	Hives or Rash	Y / N	Sickle Cell Anemia	Y / N
Artificial Joint	Y / N	Excessive Bleeding	Y / N	Hypoglycemia	Y / N	Sinus Trouble	Y / N
Asthma	Y / N	Excessive Thirst	Y / N	Irregular Heartbeat	Y / N	Spina Bifida	Y / N
Artificial Heart Valve	Y / N	Fainting Spells	Y / N	Kidney Problems	Y / N	Stomach/Intestinal Disease	Y / N
Blood Disease	Y / N	Frequent Coughs	Y / N	Leukemia	Y / N	Stroke	Y / N
Blood Transfusion	Y / N	Frequent Diarrhea	Y / N	Liver Disease	Y / N	Swelling of Limbs	Y / N
Breathing Problems	Y / N	Frequent Headaches	Y / N	Low Blood Pressure	Y / N	Thyroid Disease	Y / N
Bruise Easily	Y / N	Genital Herpes	Y / N	Lung Disease	Y / N	Tonsilitis	Y / N
Cancer	Y / N	Glaucoma	Y / N	Mitral Valve Prolapse	Y / N	Tuberculosis	Y / N
Chemotherapy	Y / N	Hay Fever	Y / N	Osteoporosis	Y / N	Tumors or Growths	Y / N
Chest Pains	Y / N	Heart Attack / Failure	Y / N	Pain in Jaw Joints	Y / N	Ulcers	Y / N
Cold Sores/Fever Blisters	Y / N	Heart Murmur	Y / N	Parathyroid Disease	Y / N	Venereal Disease	Y / N
Congenital Heart Disorder	Y / N	Heart Pace Maker	Y / N	Psychiatric Care	Y / N	Yellow Jaundice	Y / N
Convulsions	Y / N	Heart Trouble /Disease	Y / N	Radiation Treatments	Y / N	Sleep Apnea	Y / N
Family/Personal Hx of Oral Cancer	Y / N	Hemophelia	Y / N	Recent Weight Loss	Y / N	Human Papillo Mavirus	Y / N

Have you ever had any serious illness not listed above? If yes, please explain:__________________________________

____

Comments:____

____

Dental History

Reason for today's visit:____

Are you in pain?____

Do you smoke/chew tobacco?__________ If yes, how long?________________

Former Dentist____________________________City/State__________________________

Date of Last visit________________________ Date of Last X-rays________________________

***Whom may we thank for referring you?*____**

Are you happy with your teeth's appearance?____
Are you happy with the function of your teeth?____
Is there anything you would change about your teeth?____
Have you ever had a bad dental experience? ____ If yes, please describe:______________________________
____

Would you be interested in **conscious sedation**, if it meant more treatment at one visit and fewer appointments? Y / N

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

Bad Breath	Y / N	Bleeding Gums	Y / N
Blisters on/around Mouth	Y / N	Burning Sensation on Tongue	Y / N
Cigarette, Cigar Smoking	Y / N	Chew on one side of mouth	Y / N
Dry Mouth	Y / N	Fingernail Biting	Y / N
Foreign Objects	Y / N	Lip or Cheek Biting	Y / N
Loose Teeth	Y / N	Broken Fillings	Y / N
Mouth Breathing	Y / N	Mouth Pain, Brushing	Y / N
Orthodontic Treatment	Y / N	Pain Around Ear	Y / N
Periodontal Treatment	Y / N	Sores/Growths in Mouth	Y / N

If answering Yes to any of the following please explain:

Food Collection Between Teeth Y / N____
Grinding Teeth Y / N ____
Gums Swollen or Tender Y / N____
Jaw Pain or Tiredness Y / N ____
Sensitivity to Heat Y / N ____
Sensitivity to Cold Y / N ____
Sensitivity to Sweets Y / N ____
Sensitivity when Biting Y / N ____

How often do you floss?________________________ How often do you brush?________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian________________________________Date________________