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 #*

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

DENTAL HISTORY

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

Y/N

☐☐ Headaches, ear aches, neck pain
☐☐ Mouth ulcers or cold sores
☐☐ Jaw joint pain
☐☐ Broken tooth or Broken fillings
☐☐ Grinding or clenching teeth
☐☐ Bleeding, swollen or irritated gums
☐☐ Loose, tipped or shifted teeth
☐☐ Bad breath or bad taste in your mouth
☐☐ Trouble sleeping

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

Y/N

☐☐ Dentures
☐☐ Partial dentures
☐☐ Braces
☐☐ Gum treatments

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/vapor cigarettes or use smokeless tobacco? How much? For how long?

_____

If you could change your smile, you would:

Y/N

☐☐ 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

Y / N	Y / N	Y / N	Y / N
☐☐ Allergies (Seasonal)	☐☐ Excessive Bleeding	☐☐ Nervousness/Depression	☐☐ Ulcers
☐☐ Anemia	☐☐ Glaucoma	☐☐ Pacemaker	☐☐ OTHER (please list):
☐☐ Artificial Heart Valve	☐☐ Heart Conditions	☐☐ Phen Fen (1 month +)	_____
☐☐ Artificial Joints	☐☐ Heart Murmur	☐☐ Radiation (head/neck)	_____
☐☐ Asthma	☐☐ Hepatitis A	☐☐ Respiratory Problems	_____
☐☐ Blood Disease	☐☐ Hepatitis B	☐☐ Rheumatic Fever	_____
☐☐ Bruise Easily	☐☐ Hepatitis C	☐☐ Rheumatism	_____
☐☐ Cancer	☐☐ High Blood Pressure	☐☐ Scarlet Fever	_____
☐☐ Chemotherapy	☐☐ HIV/AIDS	☐☐ Seizures	**For WOMEN Only**
☐☐ Diabetes	☐☐ Jaundice	☐☐ Stomach Problems	☐☐ Birth Control Pills
☐☐ Dizziness/Fainting	☐☐ Kidney Disease	☐☐ Stroke	☐☐ Breast-feeding
☐☐ Drug Addiction	☐☐ Liver Disease	☐☐ Thyroid Disease	☐☐ Pregnant
☐☐ Emphysema	☐☐ Mitral Valve Prolapse	☐☐ Tuberculosis	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 currently taking?

_____
_____

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

_____

Family Physician _____ **Phone Number** _____

Is there any other medical or dental history we should know?_____