

PATIENT REGISTRATION

TODAY'S DATE _____

Patient's Name _____ Birthdate _____ Age _____ Sex: M F

Home Address	City	State	Zip
Home Phone Number	<i>Please Circle One:</i>		Your Soc Sec. #
Your Employer	Single, Married, Separated, Widow		
	Occupation	Work Phone #	

Are you a full time student? Yes No *If patient is minor we need:* *Mother's Name & Birthdate* *Father's Name & Birthdate*

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 any other medical or dental information we should know about?

Patient Signature (or Parent of Child) _____ Date _____ Dentist's Signature _____

DENTAL HISTORY

Please check any of the following that apply to you:

- Sensitivity (hot, cold, sweet)
Where? UR LR UL LL
- Headaches, ear aches, neck or jaw joint pain
- Mouth ulcers or cold sores
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

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

- 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 or use chewing tobacco?
How much? _____ For how long? _____

If I could change my smile, I would:

- Make my teeth whiter
- Make my teeth straighter
- Close spaces
- Replace metal fillings with tooth colored restorations
- 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:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Allergies (Seasonal) | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> OTHER (please list): |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Phen Fen (1 month +) | _____ |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation (head/neck) | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Respiratory Problems | _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures | For WOMEN Only |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Breast-feeding |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis | 1-3 mos, 3-6 mos, 6-9 mos, |

Do you have an allergy to any of the following?

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | What medications are you currently taking? |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Latex | _____ | |
| <input type="checkbox"/> Local Anesthetic | _____ | |
| <input type="checkbox"/> Nitrous Oxide | _____ | |
| <input type="checkbox"/> Penicillin | _____ | |

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

Family Physician _____ **Phone Number** _____