PATIENT REGISTRATION

Print This Form

TODAY'S DATE_____

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

Home Address	**City**	**State**	**Zip**

Home Phone Number	***Please Circle One:***	
	Single, Married, Separated, Widow	**Your Soc Sec. #**
Your Employer	**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:

☐ 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
☐ OTHER (please list):
_____
_____
_____
_____
_____
_____

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

What medications are you currently taking?

_____
_____
_____
_____

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

_____

_____

Family Physician _____ **Phone Number** _____