

PATIENT REGISTRATION

TODAY'S DATE _____

Patient's Name		Birth date		Age	Sex: M F
Home Address		City	State	Zip	
Home Phone #		<i>Please Circle One:</i> Single, Married, Separated, Widow		Your Social Security Number	
Your Employer		Occupation		Work Phone #	
Are you a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>If patient is minor we need Mother & Father's Names & Birth date</i>			
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					
<i>Name, Address, & Telephone of A relative not living with you:</i>					
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	

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

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:

- | | | | |
|---|--|---|---|
| <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
