

Patient Registration Form

Email: _____ Today's Date: _____

Preferred Name: [] Miss [] Mr. [] Mrs. [] Ms. [] Dr. _____ Referred by: _____

Name: _____ () _____ () _____
Last First Middle Home Phone Cell Phone

Address: _____
Mailing Address City State Zip

SS#: - - Date of Birth: / / Sex: [] M [] F

Employer: _____ Business Phone: _____

Emergency Contact: _____ Relationship: _____ Home Phone: _____ Cell Phone: _____

College Student Status: [] Full Time [] Part Time School Name: _____

Employment Status: Full Time Part Time Retired Address: _____

Marital Status: [] Married [] Single [] Divorced [] Separated [] Widowed Address 2: _____

Pharmacy: _____ Phone: () _____ City, State, Zip: _____

Dental Insurance Information

Primary Dental Insurance

Name of insured: _____ Relationship to Patient: [] Self [] Spouse [] Child [] Other

Insured SS#: _____ Insured Birthdate: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

ID#: _____ Gr#: _____

Secondary Dental Insurance Information

Name of insured: _____ Relationship to Patient: [] Self [] Spouse [] Child [] Other

Insured SS#: _____ Insured Birthdate: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

ID#: _____ Gr#: _____

Dental Information

Do your gums bleed when you brush or floss?	Y N	Do you have earaches or neck pain?	Y N
Are your teeth sensitive to hot, cold, sweets, or pressure?	Y N	Do you have any clicking, popping or pain in your jaw?	Y N
Is your mouth dry?	Y N	Do you brux or grind your teeth?	Y N
Have you ever had any periodontal treatment?	Y N	Do you have sores or ulcers in your mouth?	Y N
Have you ever had orthodontic treatment?	Y N	Do you wear dentures or partials?	Y N
Have you had problems associated with previous treatment?	Y N	Do you participate in active recreational activities?	Y N
Is your home water supply fluoridated?	Y N	Have you ever had serious injury to head or mouth?	Y N
Do you drink bottled or filtered water?	Y N	Date of your last dental exam:	Y N
If yes, how often? [] Daily [] Weekly [] Occasionally		What was done at that time?	
Are you currently experiencing dental pain or discomfort?	Y N	Are you happy with your smile? [] Yes! [] No.	
What is the reason for your visit today?			

Signature: _____ Date: _____

Medical InformationAre you now under the care of a physician? Yes No

Physician Name: _____

Phone: _____ Fax: _____

Address : _____

City: _____ State: _____ Zip: _____

Are you in good health? Yes No

Has there been any change in your general health in the past year?

If yes, what condition was treated? _____

Date of your last physical exam: _____

Do you wear contact lenses? Yes NoAre you taking, or have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine), or fen-phen (fenfluramine-phentermine combination)? Yes NoAre you taking or scheduled to begin taking either of the medications alendronate (Fosamax) or risendronate (Actonel) for osteoporosis or Paget's disease? Yes NoWere you treated with or are you presently scheduled to begin treatment with the intravenous biophosphonates (Aredia or Zometa) for bonepain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? Yes No

Date treatment began: _____

Have you has a serious illness, operation or been hospitalized in the last 5 years? Yes No
If yes what was the illness or problem? _____Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes No

If yes, Please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____

Do you use controlled substances or drugs? Yes NoDo you use tobacco (Smoking, snuff, chew, bidis) Yes No
If so, how interested are you in stopping?
 Very Somewhat Not InterestedDo you drink alcoholic beverages? Yes No

How much alcohol did you drink in the last 24 hours? _____

How much do you typically drink in a week? _____

Women Only Are you:

Pregnant? Yes No Number of weeks: _____Nursing? Yes NoTaking birth control pills or hormone replacement? Yes NoJoint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? Yes No Date: _____

If yes, list complications: _____

Allergies – Please check all that apply and specify reaction for each checked allergies. Local anesthetic: _____ Aspirin: _____ Penicillin or other antibiotics: _____ Barbituates, sedatives, or sleeping pills: _____ Sulfa drugs: _____ Codeine or other narcotics: _____ Metals: _____ Latex (rubber): _____ Iodine: _____ Hay fever / seasonal: _____ Animals: _____ Food: _____ Other: _____Heart murmur Y NAnemia Y NChest pain upon exertion Y NNeurological disorders Y NMitral valve prolapse Y NBlood transfusion Y NChronic pain Y N

If yes specify: _____

Artificial heart valves Y N

If yes, date: _____

Diabetes - Type I or II Y NSleep disorder Y NRheumatic fever Y NHemophilia Y NEating disorder Y NMental health disorder Y NCardiovascular disease Y NAIDS or HIV infection Y NMalnutrition Y N

If yes, specify: _____

Angina Y NArthritis Y NGastrointestinal disease Y NRecurrent infections Y NArteriosclerosis Y NAutoimmune disease Y NG.E. Reflux / Persistent heartburn Y N

Type of infection: _____

Congestive heart failure Y NRheumatoid Arthritis Y NUlcers Y NKidney problems Y NCoronary heart disease Y NSystemic lupus erythematosus Y NThyroid problems Y NNight sweats Y NDamaged heart valves Y NAsthma Y NStroke Y NOsteoporosis Y NHeart Attack Y NBronchitis Y NGlaucoma Y NPersistent swollen glands in the neck Y NLow blood pressure Y NEmphysema Y NHepatitis, jaundice, or Liver disease Y NSevere headaches / Migraines Y NHigh blood pressure Y NSinus trouble Y NEpilepsy Y NSTD's Y NCongenital heart defects Y NTuberculosis Y NFainting spells or seizures Y NSever or rapid weight loss Y NPacemaker Y NCancer, chemotherapy, or Radiation treatment Y NRheumatic heart disease Y NAbnormal bleeding Y NHas any physician or dentist recommended that you take antibiotics prior to your dental treatment? Y N

Name of the physician or dentist making recommendation: _____

Do you have any disease, condition, or problem not listed above that you think your dentist should know about? Y N

Please explain: _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff, responsible for any action that they take or do not take because of errors or omissions that I have made in completion of this form.

Date: _____

Signature of Patient / Legal Guardian: _____