Patient Registration

Name:_________________________________Sex: Circle M F Birthdate:________Age:_____Soc. Security#____________________

Home Address:___________________________City___________________State______Zip_______

Home Ph#_________________Cell Ph#____________________Email:_________________________

Your Employer:____Work Ph#_________________________

Person Responsible for the Account:_________________________Relationship:__________________

Name of Spouse (or parent if minor)_________________________________

Emergency Information: (Name, Address, and Telephone of a person not living with you):

____

How did you hear about our office?__________________________

If Patient is a minor, we need:

Mother's DOB: ____________________Father's DOB:__________________

Dental Insurance Information
Medical History

Dental Insurance Info		Secondary Insurance Info	
Policy Holder's Name		Policy Holder's Name	
Policy Holder's Employer		Policy Holder's Employer	
Insurance Company		Insurance Company	
Insurance Company Address		Insurance Company Address	
Phone #		Phone #	
DOB		DOB	
SS#		SS#	
Group #		Group #	
Policy #		Policy #	

Are you under a physician's care now? What for?____

What medications are you currently taking?____

Family Physician/Physician Ph #:____

Have you ever been hospitalized or had a major operation? (If yes, for what and when)________________

____

Have you ever had a severe head or neck injury? _____________________________________

Medical History (continued)
Do you take, or have you taken, Phen-Fen or Redux? Circle Y or N
Are you on a special diet? Circle Y or N
Do you use controlled substances? Circle Y or N
If yes
____
Are you pregnant/trying to get pregnant? Circle Y or N
Are you nursing? Circle Y or N
Are you taking oral contraceptives? Circle Y or N

Are you allergic to any of the following?
- Aspirin
- Metal
- Penicillin
- Latex
- Codeine
- Sulfa Drugs
- Acrylic
- Local Anesthetics
- Nitrous Oxide
- Percodan
- Tetracycline
- Erythromycin
- Valium
- Other____

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

Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?
____
____
____

Please check any of the following problems/conditions that apply to you:
- AIDS
- Alzheimer's Disease
- Anaphylaxis
- Anemia
- Angina
- Arthritis/Gout
- Artificial Heart Valve
- Artificial Joint
- Asthma
- Blood Disease
- Blood Transfusion
- Breathing Problems
- Bruise Easily
- Cancer
- Chemotherapy
- Chest Pains
- Cold Sores/Fever Blisters
- Congental Heart Disorder
- Convulsions
- Cortisone Medicine
- Diabetes
- Drug Addiction
- Easily winded
- Emphysema
- Epilepsy or Seizures
- Excessive Bleeding
- Excessive Thirst
- Fainting Spells/Dizziness
- Frequent Cough
- Frequent Diarrhea
- Frequent Headaches
- Genital Herpes
- Glaucoma
- Hay Fever
- Heart attack/Failure
- Heart Murmur
- Heart Trouble/Disease
- Hemophilia
- Hepatitis A
- Hepatitis B or C
- Herpes
- High Blood Pressure
- High Cholesterol
- Hives or Rash
- Hypoglycemia
- Irregular Heartbeat
- Kidney Problems
- Leukemia
- Liver Disease
- Low Blood Pressure
- Lung Disease
- Mitral Valve Prolapse
- Osteoporosis
- Pain in Jaw Joints
- Parathyroid Disease
- Psychiatric Care
- Radiation Treatments
- Recent Weight Loss
- Renal Dialysis
- Rheumatic Fever
- Rheumatism
- Scarlet Fever
- Shingles
- Sickle Cell Disease
- Sinus Trouble
- Spina Bifida
- Stomach/Intestinal Disease
- Stroke
- Swelling of Limbs
- Thyroid Disease
- Tonsilitis
- Tuberculosis
- Tumors or Growths
- Ulcers
- Venereal Disease
- Yellow Jaundice
- Other_____________________
  ____

Dental History
Please check any of the following problems that apply to you:
- Sensitivity
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

Do you have or had you had any of the following?
- Dentures
- Partial Dentures
- Braces
- Periodontal (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:_________________

What is the most important thing to you about your future smile and dental health?
____
____
____
____
____
____

What is the most important thing to you about your dental visit today?
____
____
____
____
____
____

Do you smoke or use chewing tobacco? Circle Y or N
How much?___________
For how long?____________

Are you interested in sedation dentistry? Circle Y or N

Would you like additional information about financing options? Circle Y or N

If I could change my smile, I would (Please check any that apply):
- Make it whiter
- Make it straighter
- Close spaces
- Replace black metal fillings with tooth colored restorations
- Repair broken or chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover