PATIENT REGISTRATION

TODAY'S DATE_____

Patient's Name	**Birth date**		**Age**	**Sex:** **M F**
Home Address	**City**	**State**	**Zip**	
Home Phone #	***Please Circle One:*** Single, Married, Separated, Widow		**Your Social Security Number**	
Your Employer	**Occupation**		**Work Phone #**	
Are you a full time student? ☐Yes ☐ No	*If patient is minor we need Mother & Father's names & birth date*			
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				
Full Name & Telephone:				
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**		
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		

Name: 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
- ☐ Lump or swelling in mouth

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

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Gum treatments

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?

_____

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

Would you be interested in teeth whitening?

_____

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

Name of Previous Dentist:

_____

City:_____ **State:**_____

Why did you leave your previous dentist?

_____

Please share the following dates:

Your last cleaning: _____/_____
Your last oral cancer screening: _____/____
Your last complete set of x-rays: _____/____

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
- ☐ 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
- ☐ Osteoporosis (taking biophosphates)
- ☐ Often Fatigued/Exhausted
- ☐ Pacemaker
- ☐ Phen Fen
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sleep/Breathing Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumor/abnormal growth
- ☐ Ulcers
- ☐ Other:

_____
_____
_____

Women ONLY

- ☐ Birth Control
- ☐ Breast-feeding
- ☐ Pregnant
  - 1-3 mo.
  - 3-6 mo.
  - 6-9 mo.

What medications are you currently taking?

_____

_____

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

_____

Family Physician Name & Number:

_____

Are you allergic to any of the following?

- ☐ Asprin
- ☐ Erythromycin
- ☐ Latex
- ☐ Fluoride
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Other:
- ☐ Codeine
- ☐ Sulfa
- ☐ Metal

_____

Doctor's Signature:_____

Doctor’s Signature:____