PATIENT REGISTRATION

Name_____ Date of Birth_____

Address_____City_____ State_____ Zip_____

Cell Phone_____ Work Phone_____Home Phone_____

Would you like a Text Appointment Confirmation (when available)? ___YES ___NO

__Male __Female __Single __Married __Separated __Divorced __Widowed

Social Security Number(for insurance)_____ Driver's License and State _____

Employer_____ Location_____ Position_____

Primary Dental Insurance Co. _____Group # _____ Subscriber ID_____

Secondary Dental Insurance Co. _____Group # _____ Subscriber ID _____

RESPONSIBLE PARTY (for children thru 17 or patients with guardians) Otherwise just write self.

Name _____ Birthdate_____ Cell/Home Phone _____

Relationship to Patient _____

Social Security Number_____ Driver's License and State _____

Address_____ City_____State_____ Zip_____

Responsible Person's Employer _____

Business Address _____City _____ State _____ Zip_____

Spouse's Name(If applicable) _____Social Security #_____ Birthdate _____

Spouse's Employer _____ Spouse's Cell Phone_____

Spouse's Work Address _____ City _____State _____ Zip _____

How did you hear about our office?

___Referred by a friend ___Digital Advertising ___On-line (directory or advertisement) ___Insurance Plan

___Discount Mailer (i.e. Valpak) ___Drive-by/Signage ___Postcard or Letter ___I am a current Patient

If you were referred, who may we thank you for referring you? _____

CONSENT

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

_____ _____ _____

Signature Date Relationship to Patient

-over-

PATIENTS DENTAL HEALTH

Why have you come to see us today? (pain, checkup, etc)_____

Previous Dentist_____ Last Visit_____ Date of last cleaning_____

Reason for Changing Dentist_____

What problems have you had with [past dental treatment? _____

Are you nervous about seeing a dentist? _____Yes _____No If yes, please tell us why_____

How often do you brush? _____ Do you floss? _____Yes _____No How often? _____

(**Please Circle Each)**

Y N I clench or grind my teeth during the day or while sleeping
Y N My gums bleed while brushing or flossing
Y N I like my smile
Y N I prefer tooth colored fillings
Y N I avoid brushing part of my mouth due to pain
Y N My gums feel tender or swollel
Y N I have problems eating
Y N I have had orthodontics
Y N I have had a facial or jaw injury
Y N I want my teeth straight
Y N I want my teeth whiter

What are your dental priorities? _____
(e.g. dental health, financial considerations, etc.)

PATIENT'S MEDICAL HISTORY

I consider my health to be (please circle one) Excellent Good Fair Poor

Do you or have you had any of the following? Please circle Y for Yes or N for No

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure High or Low
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints:_____ Hip_____ Knee_____ Other
16. Y N I smoke or use tobacco If Yes, how much per day? _____ How many years? _____
17. Y N I have consumed alcohol in the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment
19. Y N I have had a major surgery: Year _____ Type of Operation _____ Year _____ Type of Operation_____
20. Y N Liver Disease
21. Y N Jaundice
22. Y N Hepatitis Type_____
23. Y N Diabetes
24. Y N Excessive Urination/Thirst
25. Y N Infectious Mononucleosis (Mono)
26. Y N Herpes
27. Y N Arthritis
28. Y N Sexually Transmitted/Venereal Disease
29. Y N Kidney Disease
30. Y N Tumor or Malignancy
31. Y N Cancer/Chemotherapy_____
32. Y N Radiation Treatment
33. Y N History of Drug Addiction
34. Y N AIDS
35. Y N Immune Suppresses Disorder
36. Y N Hearing Loss
37. Y N Fainting Spells
38. Y N Glaucoma
39. Y N History of Emotional or Nervous Disorder

WOMEN

40. Y N Are you taking birth control medication
41. Y N Are you or could you be pregnant or nursing
42. Y N Have you taken Fosamax for Osteoporosis?

Do you have any other medical problem or medical history NOT listed on this form? _____

Are you allergic to ANY of the following?
Please circle Y for yes N for No

Y N Aspirin
Y N Ibuprofen
Y N Sulfa Drugs/Sulfites/Sulfides
Y N Penicillin
Y N Codeine
Y N Latex, Metals, Plastic
Y N Local Anesthetics (Novocaine)
Y N Other Medications-which ones? _____

Please list ALL medications you are currently taking

Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____
Medicine_____ Condition_____
Physician's Name_____ Phone Number_____
Fax Number_____

I have answered all health questions to the best of my knowledge

Sinature_____Date_____Reviewed By_____Date_____