Patient Registration

First Name _____**Last Name**_____

Address_____**City**_____**State**_____**Zip**_____

Sex: M F Birth Date:__/__/__ Marital Status: S M W D Email:_____

Social Security#_____ **Drivers Lic#**_____ **Employer**_____

Employer Address_____ **City**_____ **State**_____ **Zip**_____

Home phone _____ **Work phone** _____ **Cell phone** _____

WHO REFERRED YOU TO OUR OFFICE? _____

Contact preference:* ☐*Home phone* ☐*Work phone* ☐*Cell phone (*☐call/☐text) ☐*Email

DENTAL INSURANCE INFORMATION-PRIMARY

Name of Insured/Policyholder: _____**ID#**_____

Social Security # _____ **Birth Date:** _____**Employer:** _____

Dental Insurance Company_____

****Please bring your insurance card and Driver's License, we will make a copy of your insurance card and your Driver's License at your appointment****

Dental History

Reason for visit: _____ **Date of last dental visit?** _____

How often do you brush your teeth? _____

What texture brush do you use? ☐Soft ☐Medium ☐Hard

	YES	NO
1. Do your gums bleed while brushing?	☐	☐
2. Do you floss?	☐	☐
3. Do your gums bleed while flossing?	☐	☐
4. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	☐	☐
5. Have you noticed any loosening of your teeth?	☐	☐
6. Does food tend to get caught between your teeth easily?	☐	☐
7. Do you have any sores or lumps in or near your mouth?	☐	☐
8. Have you ever experienced any of the following problems in your jaw:		
a. Clicking?	☐	☐
b. Pain? (joint, ear, side of face)	☐	☐
c. Difficulty opening or closing?	☐	☐
d. Difficulty in chewing?	☐	☐

	YES	NO
9. Do you have frequent headaches?	☐	☐
10. Do you clench or grind your teeth while awake or asleep?	☐	☐
11. Do you bite your cheeks frequently?	☐	☐
12. Have you ever had:		
a. Orthodontic treatment?	☐	☐
b. Oral surgery?	☐	☐
c. Gum treatment?	☐	☐
d. Your bite adjusted?	☐	☐
e. Worn a bite plane/other appliance?	☐	☐
13. Is there anything you would like to change about your smile?	☐	☐
14. Can you chew everywhere comfortably?	☐	☐
15. **Electric** or **Manual** tooth brush (circle one)		

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MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you are taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Please circle YES or NO to those that apply:

Have you ever been told to pre-medicate for dental treatment? ……Yes No
Are you under a physician's care now?.....Yes No
If Yes, Name of Physician_____
Have you ever been hospitalized or had a major operation?.....Yes No
Have you ever had a serious head or neck injury?.....Yes No
Do you have or have you taken Phen-Fen or Redux?.....Yes No
Have you taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?.....Yes No
Are you on a special diet?.....Yes No
Do you use tobacco?.....Yes No
Do you use controlled substances?.....Yes No

Women: Are you:
Pregnant/ Trying to get pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

Do you have, or have you had, any of the following? (Check only those that apply)

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphalaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve*
- ❑ Artificial Joint*
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sore/Fever Blister
- ❑ CongenitalHeartDisorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Dry Mouth
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever/Allergies
- ❑ Heart Attack/Failure
- ❑ Heart Murmur*
- ❑ Heart Pace Maker
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitus A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ High Cholesterol
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse*
- ❑ Multiple Sclerosis
- ❑ 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
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

*Condition may require Pre-Medication

Have you ever had any serious illness not listed above? Yes No _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

LIST ALL DRUG ALLERGIES:

❑ASPIRIN ❑PENICILLIN

❑SULFA ❑LATEX

❑CODEINE ❑LOCAL ANESTHETICS

❑OTHER:_____

PHARMACY:_____ LOCATION:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ***DATE***