

PATIENT REGISTRATION INFORMATION

Patient Information

First Name: _____
Last Name: _____
Middle Initial: _____ Nickname: _____
Address: _____
Address 2: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____
Work Phone: _____
Cellular Phone: _____
Pager: _____
Gender: Male Female
Marital Status: Married Single
 Divorced Separated
 Widowed Minor
Date of Birth: _____ Social Sec. #: _____
Driver's License Number: _____
Email: _____
May we email correspondence?
 Yes No
Employment Status: Full Time Part Time
 Retired Unemployed
Student Status: Full Time Part Time
Emergency Contact: _____
Emergency Numbers: _____

Responsible Party Information

(leave blank if same as Patient Information)

First Name: _____
Last Name: _____
Middle Initial: _____ Nickname: _____
Address: _____
Address 2: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____
Work Phone: _____
Cellular Phone: _____
Pager: _____
Gender: Male Female
Marital Status: Married Single
 Divorced Separated
 Widowed Minor
Date of Birth: _____ Social Sec. #: _____
Driver's License Number: _____
Email: _____
May we email correspondence?
 Yes No
Does your cell phone receive text messages?
 Yes No
 Responsible Party is also a Policy Holder for Patient
 Primary Insurance Policy Holder
 Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____
Relationship to Patient: Self Female
 Child Other
Insured Soc. Security: _____
Insured Birth Date: _____
Employer: _____
Address: _____
Address 2: _____
City: _____ State: _____ Zip Code: _____
Insurance Company: _____
Address: _____
Address 2: _____
City: _____ State: _____ Zip Code: _____
Remain. Benefits: _____ Remain. Deductible: _____

Secondary Insurance Information

Name of Insured: _____
Relationship to Patient: Self Female
 Child Other
Insured Soc. Security: _____
Insured Birth Date: _____
Employer: _____
Address: _____
Address 2: _____
City: _____ State: _____ Zip Code: _____
Insurance Company: _____
Address: _____
Address 2: _____
City: _____ State: _____ Zip Code: _____
Remain. Benefits: _____ Remain. Deductible: _____

MEDICAL/DENTAL HISTORY

Current Physician _____ Location _____ Office Phone _____ Date of Last Exam: _____

- Yes No Are you under a physician's care now?
If yes, please explain: _____
- Yes No Have you ever been hospitalized/major operation?
If yes, please explain: _____
- Yes No Have you ever had a serious head or neck injury?
If yes, please explain: _____
- Yes No Are you taking any medications, pills, or drug?
If yes, please explain: _____
- _____
- Yes No Do you take, or taken bone building drugs?
 Yes No Do you take, or taken, Phen-Fen or Redux?
 Yes No Do you use controlled substances?
 Yes No Do you use tobacco?
 Yes No Are you on a special diet?

- Are you allergic to or have you had any reactions to the following:
- Yes No Aspirin
 Yes No Penicillin or any other Antibiotics
 Yes No Codine
 Yes No Acrylic
 Yes No Any Metals (eg. nickel, mercury, etc)
 Yes No Latex Rubber
 Yes No Local Anesthetics (eg. novocaine)
 Yes No Sulfa Drugs
 Yes No Other _____

- Women Only:** (check all that apply)
- Yes No Are you taking oral contraceptives?
 Yes No Are you pregnant/trying to get pregnant?
 Yes No Are you nursing?

Do you have, or have you had, any of the following medical conditions? (check all that apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Recent Weight Loss | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Previous Dentist _____ Location _____ Office Phone _____ Date of Last Exam: _____

Do you have, or have you had, any of the following dental conditions? (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Bleeding gums while brushing or flossing | Experienced any of the following in your jaw: | <input type="checkbox"/> Difficult extractions in the past |
| <input type="checkbox"/> Sensitivity to hot/cold liquids/foods | <input type="checkbox"/> Clicking | <input type="checkbox"/> Prolonged bleeding following extractions |
| <input type="checkbox"/> Sensitivity to sweet/sour liquids/foods | <input type="checkbox"/> Pain | <input type="checkbox"/> Wear dentures or partials,
if yes date of replacement: _____ |
| <input type="checkbox"/> Pain to any of your teeth | <input type="checkbox"/> Difficulty in opening or closing | |
| <input type="checkbox"/> Sores or lumps near your mouth | <input type="checkbox"/> Difficulty in chewing | <input type="checkbox"/> Received oral hygiene instructions
regarding the care of your teeth and gums |
| <input type="checkbox"/> Head, neck or jaw injuries | <input type="checkbox"/> Clenching or grinding of teeth | <input type="checkbox"/> Like your smile |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Frequent biting of lips or cheeks | |
| | <input type="checkbox"/> Orthodontic treatments | |

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.

Patient's Name

Signature (parent if patient is under the age of 18)

Date

Print Name (parent if patient is under the age of 18)

Staff Initials