Patient Registration

ID _____

Chart ID _____

Name: _____ _____ _____ _____
Last First Mid

Patient Is:

_____ Policy Holder

_____ Responsible Party

Preffered Name: _____

Responsible Party *(if someone other than the patient)*

Last: _____ Mid:_____ First: _____

Address: _____ Pager _____

City: _____ State: _____ Zip: _____

Address 2: _____

Driver's license number : _____

Birt Date: __/__/____ SSN: ___-___-____

Home phone #: (___) - ___ - ____

Cellular #: (___) - ___ - ____

Work Phone #: (___) - ___ - ____ Ext: ____

_____ Responsible Party is also a policy holder for patient

_____ Primary Insurance Policy Holder

_____ Secondary Insurance Policy Holder

Patient Information-

Address: _____ Pager _____

City: _____ State: _____ Zip: _____

Address 2: _____

Your marital status: _____ Sex: _____

Driver's license number : _____

Birt Date: __/__/____ Age:_____ SSN: ___-___-____

Email address : _____

Home phone #: (___) - ___ - ____

Cellular #: (___) - ___ - ____

Work Phone #: (___) - ___ - ____ Ext: ____

_____ I would like to receive correspondences via e-mail.

Section 02

_____ Employment status

_____ Student status

Medicaid ID: _____

Employer ID: _____

Carrier ID: _____

Pref. Dentist: _____

Pref. Pharmacy: _____

Pref. Hyg.: _____

Section 03

Referral Source: _____

Patient Value: _____

Occupation : _____

Spouses Name: _____

Kids Names: _____

Hobbies: _____

Pets Names: _____

Insurance information

Primary Insurance Information

Name of Insured:_____

Relationship to Insured: _____

Insured's Birth Date: __/__/____ Insured SSN: ___-___-____

Employer Details-

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Address 2: _____

Rem. Benefits:_____

Rem. Deduct:_____

Insurance Company Details -

Ins. Company:_____

Address: _____

City: _____ State: _____ Zip: _____

Address 2: _____

Secondary Insurance Information

Name of Insured:_____

Relationship to Insured: _____

Insured's Birth Date: __/__/____ Insured SSN: ___-___-____

Employer Details-

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Address 2: _____

Rem. Benefits:_____

Rem. Deduct:_____

Insurance Company Details -

Ins. Company:_____

Address: _____

City: _____ State: _____ Zip: _____

Address 2: _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication.

Are you under a physician care now? _____

If Yes: _____

Have you ever been hospitalized or had a major operation? _____

If Yes: _____

Have you ever had a serious head or neck injury? _____

If Yes: _____

Are you taking any medications, pills or drugs? _____

If Yes: _____

Have you ever taken Fosamax,Boniva, Actonel or any other medications containing bisphosphonates? _____

If Yes: _____

Do you use tobacco? _____

Women Are You : Pregnant/Trying to get pregnant?_____

Nursing? _____ Taking oral Conttraceptives? _____

Have you ever had any of the following diseases or medical problems

AIDS/HIV Positive	_____	Ulcers	_____
Diabetes	_____	Lupus	_____
Drug Addiction	_____	Radiation Treatments	_____
Herpes	_____	Recent Weight Loss	_____
Arthritis/Gout	_____	Anemia	_____
Hives or Rash	_____	Lung Disease/ Emphysema	_____
Sickle Cell Disease	_____	High Cholesterol	_____
Sinus Trouble	_____	Excessive Thirst	_____
Leukemia	_____	Fainting Spells/ Dizziness	_____
Liver Disease/Jaundice	_____	Kidney Problems	_____
Swelling of Limbs	_____	Breathing Problems	_____
Chemotherapy	_____	Bruise Easily	_____
Heart Attack/Failure	_____	Glaucoma	_____
Heart Murmur	_____	Tonsillitis	_____
Heart Pacemaker	_____	Tuberculosis	_____
Venereal Disease	_____	Tumors or Growths	_____
Hemophilia	_____	Heart Trouble/ disease	_____
Hepatitis A/B/C	_____	Anxiety/ Nervous Disorder	_____
Renal Dialysis	_____	Alzheimers Disease	_____
Angina	_____	Anaphylaxis	_____
Epilepsy / seizures	_____	Easily Winded	_____
Artifical Joint/ Heart valve	_____	High Blood Pressure	_____
Asthma	_____	Excessive Bleeding	_____
Blood Disease	_____	Hypoglycemia	_____
Stomach/ Intestinal Disease	_____	Irregular Heartbeat	_____
Stroke	_____	Spina Bifida	_____
Cancer	_____	Frequent Headaches	_____
Mitral Valve Prolapse	_____	Low Blood Pressure	_____
Osteoporosis	_____	Thyroid disease	_____
Pain in Jaw Joints	_____	Chest Pains	_____
		Cold Sores/ Fever Blisters	_____
		Congenital Heart Disorder	_____
		Psychiatric Care	_____

Have you ever had any serious illness not listed:

_____

_____

_____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Acrylic
- ☐ Local Anesthetics
- ☐ Other

Do you use controlled substances?

_____

If Yes:

_____

Dental history

Are you currently in pain? _____

Do you require antibiotics before dental treatment? _____

Have you ever had a serious/difficult problem associated with any previous dental work? _____

Have you ever had gum treatment? _____

Do you floss daily? _____

Have you ever had periodontal disease? _____

Do your gums ever bleed? _____

Do you have any loose teeth? _____

Do you still have wisdom teeth? _____

Did you wear braces? _____

Would you like fresher breath? _____

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? _____

Are you happy with the way your smile looks? _____

If not, what would you change? _____

☐ 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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: _____

Date: _____

OFFICE USE ONLY OFFICE USE ONLY

(Year 1) Initials:_____ Date:_____

(Year 2) Initials:_____ Date:_____

(Year 3) Initials:_____ Date:_____

Year 2: Changes in health _____

Date: _____ Signature_____

Year 3: Changes in health _____

Date: _____ Signature_____

Health questionnaire must be updated each year