Patient Registration

About you

Name: _____ (Last) _____ (First) _____ (Mid)

I prefer to be called: _____

Your birthday: __/__/____ Age:_____ SSN: ___-___-_____ Sex: _____

Home address: _____

City: _____ State: _____ Zip: _____APT#: _____

Email address: _____

Marital Status : ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Partnered

Home phone #: (___) - ___ - ____ Cell Phone #: (___) - ___ - ____

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

Employer: _____

Employer address : _____

City:_____ State: _____ Zip: _____ APT# : _____

How long there? _____

Occupation : _____

Where & when are best times to reach you? _____

How did you hear about us? _____

Have you visited our website? ☐ Yes ☐ No

Whom may we thank for referring you? _____

_____

Other family members seen by us: _____

_____

_____

_____

_____

Previous dentist: _____

Person responsible for account: _____

Spouse information

His / Her name: _____

Employer: _____

Work Phone #: (___) - ___ - ____ Ext: ____ Birthday : __/__/____

Cell Phone #: (___) - ___ - ____ Social Security #: ___-___-_____

Relative or friend not living with you

His / Her name: _____

Relationship: _____

Home Phone #: (___) - ___ - ____ Cell Phone #: (___) - ___ - ____

Medical insurance information

Insurance Co. name: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Insurance Co. Phone: (___) - ___ - ____

Group# (Plan, Local or Policy#):_____

Insured's name: _____

Relationship: _____

Insured's Birthday: __/__/____ SSN: ___-___-_____

Dental insurance information

Primary insurance

Dental coverage? ☐ Yes ☐ No

Insurance Co. name: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Insurance Co. Phone #: (___) - ___ - ____

Group# (Plan, Local or Policy#):_____

Insured's name: _____

Relationship: _____

Insured's Birthday: __/__/____

Insured's ID: _____

Insured's employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Secondary insurance

Dental coverage? ☐ Yes ☐ No

Insurance Co. name: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Insurance Co. Phone: (___) - ___ - ____

Group# (Plan, Local or Policy#):_____

Insured's name: _____

Relationship: _____

Insured's Birthday: __/__/____

Insured's ID: _____

Payment is due in full at the time of treatment

Unless prior arrangements have been approved.

I agree: ☐ Yes ☐ No

I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Medical History

Physician's Name: _____

Telephone home: (___) - ___ - ____ Date of last visit: __/__/____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Ever been hospitalized? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No Do you use drugs? ☐ Yes ☐ No

If so which ones? _____

Any trouble with prior surgeries? ☐ Yes ☐ No

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain:_____

_____

_____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / Over-the-counter drugs? ☐ Yes ☐ No

Please explain: _____

_____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-fen? ☐ Yes ☐ No

Is your mouth dry? ☐ Yes ☐ No

Do you have any type of hearing impairment? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

For women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: ____

Are you nursing? ☐ Yes ☐ No

Please list all medication/drugs that you are currently taking :

_____

_____

_____

Please list any serious medical condition(s) that you have ever had :

_____

_____

_____

Are you allergic to any of the following?

☐ Yes	☐ No	Aspirin	☐ Yes	☐ No	Erythromycin
☐ Yes	☐ No	Penicillin	☐ Yes	☐ No	Codeine
☐ Yes	☐ No	Jewelry / Metals	☐ Yes	☐ No	Tetracycline
☐ Yes	☐ No	Dental anesthetics	☐ Yes	☐ No	Latex
☐ Yes	☐ No	Other	☐ Yes	☐ No	Any Nuts

Please list any other drugs / Materials that you are allergic to :

_____

_____

_____

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

Yes	No		Yes	No	
☐	☐	Abnormal Bleeding / Hemophilia	☐	☐	Heart Disease
☐	☐	Herpes / Fever blisters	☐	☐	AIDS
☐	☐	Alcohol / Drug abuse	☐	☐	High blood pressure
☐	☐	Anemia	☐	☐	HIV
☐	☐	Arthritis	☐	☐	Kidney problems
☐	☐	Artificial bones / Joints / Valves	☐	☐	Liver disease
☐	☐	Asthma	☐	☐	Low blood pressure
☐	☐	Blood transfusion	☐	☐	Lupus
☐	☐	Cancer / Chemotherapy	☐	☐	Mitral valve prolapse
☐	☐	Colitis	☐	☐	Pacemaker
☐	☐	Radiation treatment	☐	☐	Psychiatric problems
☐	☐	Diabetes	☐	☐	Congenital heart defect
☐	☐	Difficulty breathing	☐	☐	Rheumatic / Scarlet fever
☐	☐	Emphysema	☐	☐	Seizures
☐	☐	Epilepsy	☐	☐	Shingles
☐	☐	Sickle cell disease / Traits	☐	☐	Fainting spells
☐	☐	Frequent headaches	☐	☐	Sinus problems
☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	Hay fever	☐	☐	Thyroid problems
☐	☐	Heart attack / Surgery	☐	☐	Tuberculosis (TB)
☐	☐	Heart murmur	☐	☐	Ulcers
☐	☐	Hepatitis	☐	☐	Aneurysm
☐	☐	Angina	☐	☐	Respiratory Problem
☐	☐	Head injury	☐	☐	STD

Dental history

Why have you come to the dentist today? _____

_____

_____

Date of your last dental visit : __/__/____

Date of your last dental cleaning : __/__/____

Date of last full mouth series of x-rays : __/__/____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is : ☐ Good ☐ Fair ☐ Poor

Dental history (Continued)

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Ever Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Are your teeth sensitive to hot, cold, sweets or anything else? ☐ Yes ☐ No

Any problems with Jaw? ☐ Yes ☐ No Mouth breather? ☐ Yes ☐ No

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No

Whiter teeth? ☐ Yes ☐ No

Does food tend to become caught between your teeth? ☐ Yes ☐ No

Do your gums often bleed when you brush your teeth ? ☐ Yes ☐ No

Have you ever had jaw surgery or a broken jaw ? ☐ Yes ☐ No

Do you clench or grind your teeth while awake or asleep? ☐ Yes ☐ No

Do you snore ? ☐ Yes ☐ No

Do you feel very nervous about having dental treatment? ☐ Yes ☐ No

Have you ever had an upsetting experience in a dental office? ☐ Yes ☐ No

Is there anything else about having dental treatment that bothers you ? ☐ Yes ☐ No

Do you expect to eventually lose your teeth? ☐ Yes ☐ No

Are you dissatisfied with the appearance of your teeth ? ☐ Yes ☐ No

Do you feel your teeth are crowded or crooked ? ☐ Yes ☐ No

Do you feel your teeth are yellow, dark or stained ? ☐ Yes ☐ No

Do you feel your smile could be improved ? ☐ Yes ☐ No

Would you like to discuss improving your smile at today's appointment ☐ Yes ☐ No

If yes to any of these questions, please explain _____

_____

_____

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? _____

_____

_____

Have you ever had

Yes / No		Yes / No	
☐	Orthodontic treatment	☐	Periodontal treatment
☐	Oral surgery	☐	Worn a bite plate

I agree: ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. If deemed advisable, I grant permission for my physician to be contacted for details and advice. For evaluation or teaching purposes I authorize the use of my radiographs or photographs. Authorization is also given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.

Signature: _____ Date: _____

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials:_____ Date:_____

Doctor's Comments:_____

_____

_____

_____

_____