PATIENT REGISTRATION

TODAY'S DATE _____

First Name_____ MI____ Last Name_____

Nickname_____ Birth Date_____ Gender □ Male □ Female

Mailing Address _____

City_____ State_____ Zip_____

How were you referred to our office?_____

Please check your telephone preference

□Home Phone_____ □Cell Phone_____

□Work Phone_____ e-mail_____

Emergency Contact_____ Phone Number_____ Relationship to patient_____

INSURANCE – Please provide copy of insurance card(s)

Primary Dental Insurance:

Insurance Company_____ Employer_____

Subscriber's Name_____ Subscriber's Birth Date_____

Subscriber's ID# (or SSN)_____ Group/Plan#_____

Relationship to Patient: □Self □Spouse □Parent □Other (Please specify)_____

Secondary Dental Insurance

Insurance Company_____ Employer_____

Subscriber's Name_____ Subscriber's Birth Date_____

Subscriber's ID# (or SSN)_____ Group/Plan#_____

Relationship to Patient: □Self □Spouse □Parent □Other (Please specify)_____

DENTAL HISTORY

Previous Dentist_____ Phone_____

Date of your last dental visit_____

Did you have a dental cleaning? □YES □NO Were x-rays taken? □YES □NO

Would you like our office to request any current x-rays from your previous dentist? □YES □NO

How often do you brush?_____ How often do you Floss?_____

Have you ever experienced any complications or problems with previous dental treatment? □YES □NO

If yes, please explain:_____

Do your gums bleed or hurt? □YES □NO

Do you have any sensitive teeth? □YES □NO

Do you have removed or lost teeth? □YES □NO

Have you ever had gum surgery? □YES □NO

Have you had orthodontic treatment? □YES □NO

Do you clench or grind your teeth? □YES □NO

Any soreness or pain in your jaw? □YES □NO

Does your jaw lock or pop? □YES □NO

Do you fear dental treatment? □YES □NO

Do you wear dentures or dental appliances? □YES □NO

Have you ever had a reaction to dental anesthetic? □YES □NO

If Yes, please describe:_____

_____

_____

MEDICAL HISTORY

Name of Physician_____Phone _____

*Heart Problems*_____
- ☐ Chest pains
- ☐ Shortness of breath
- ☐ High/Low Blood Pressure
- ☐ Heart Valve Problem/Artificial Heart Valve
- ☐ Taking heart medication
- ☐ Rheumatic Fever
- ☐ Pacemaker
- ☐ Heart murmur

Are you required to take pre-medication (prophylactic antibiotics)? □YES □NO

*Blood Problems*_____
- ☐ Easy bruising
- ☐ Frequent nose bleeds
- ☐ Abnormal bleeding
- ☐ Blood disease (anemia)
- ☐ Had blood transfusion
- ☐ Leukemia

*Allergy Problems*_____
- ☐ Hay fever / Allergies
- ☐ Sinus problems
- ☐ Skin rashes
- ☐ Taking allergy medication(s)
- ☐ Asthma

*Intestinal Problems*_____
- ☐ Ulcers
- ☐ Weight gain or loss
- ☐ Special diet
- ☐ Constipation or Diarrhea
- ☐ Kidney or bladder problems

*Other*_____
- ☐ Fainting spells, seizures, epilepsy, or other neurological disease
- ☐ Stroke(s)
- ☐ Frequent or severe headaches
- ☐ Thyroid problems
- ☐ Persistent cough or swollen glands
- ☐ Cancer/Tumor

Please describe:_____
- ☐ Diabetes
- ☐ Frequent urination
- ☐ Thirsty or dry mouth
- ☐ Family history of diabetes
- ☐ Tuberculosis or other respiratory disease
- ☐ Hepatitis, Jaundice, or Liver Disease
- ☐ Herpes or other STD
- ☐ HIV positive / AIDS
- ☐ Glaucoma
- ☐ History of head injury
- ☐ History of alcohol or drug abuse

*Bone or Joint Problems*_____
- ☐ Arthritis
- ☐ Back or neck pain
- ☐ Osteoporosis

Have you ever taken Bisphosphonates? (e.g. Fosamax, Boniva…) □YES □NO

Do you have artificial joints? (e.g. hip, knee, pins or implants?) □YES □NO

Date placed:_____

If yes, are you required to use prophylactic antibiotics (pre-medication)? □YES □NO

Do you wear contact lenses? □YES □NO

Do you use tobacco products? □YES □NO

If so, how much?_____

Do you drink alcohol? □YES □NO

If so, how much? _____

Do you have any disease, condition, or problem not listed previously that you feel we should know about? If so, please describe:_____

_____

_____

Please list any medications you have taken or are currently taking during the past 12 months:

_____

_____

_____

_____

Drug Allergies/Reactions

Have you reacted adversely or are you allergic to any of the following? (Please check)
- ☐ Dental anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Barbiturates, Sedatives, Sleeping pills
- ☐ Aspirin, Acetaminophen, Ibuprofen
- ☐ Reaction to Metals
- ☐ Codeine, Demerol, other Narcotics
- ☐ Latex or Rubber Dam

Please list any other allergies:_____

_____

_____

For Women

Do you take contraceptives/hormones? □YES □NO

Are you pregnant? □YES □NO

Are you nursing? □YES □NO

Have you reached menopause? □YES □NO

→ **Patient Signature**_____**Dentist Initial**_____