Patient Registration Form

Patient Last Name: _____ **First:** _____ **Initial:** _____

How do you wish to be addressed? _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Telephone *(Home):* _____ *(Work):* _____ *(Mobile):* _____

Email: _____ Social Security Number: _____

Insurance Information

Primary Insurance	**Secondary Insurance**
Subscriber Name: _____	Subscriber Name: _____
Subscriber ID: _____	Subscriber ID: _____
Date of Birth: _____	Date of Birth: _____
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name: _____	Employer Name: _____
Employer Phone: _____	Employer Phone: _____
Insurance Company: _____	Insurance Company: _____
Insurance Group: _____	Insurance Group: _____
Insurance Phone: _____	Insurance Phone: _____

Please present your insurance card to be photocopied for our records.

Responsible Party *(If minor)*

Last Name: _____ First: _____ Initial: _____

Address *(If different):* _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Telephone *(Home):* _____ *(Work):* _____ *(Mobile):* _____

Email: _____

Emergency Contact

Last Name: _____ First: _____ Initial: _____

Telephone *(* ☐ *Mobile* ☐ *Work* ☐ *Home):* _____

Consent

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my *(or my child's)* health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

I attest to the accuracy of the information on this page.

Signature: _____ Date: _____

(Responsible Party, if under 18)

OFFICE USE ONLY
Patient #: _____
Last updated date: _____
Blood Pressure: _____

PLEASE COMPLETE ALL INFORMATION - THANK YOU

Last Name: _____ **First Name:** _____ **Middle Initial:** ____ **Date Of Birth:** _____

Dental History

Reason for today's visit: _____ Date of last dental visit: _____

Former dentist: _____ Date of last dental x-rays: _____

Please check if you have/had:

- ☐ Bad breath
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Dry mouth
- ☐ Extra permanent teeth
- ☐ Food collection between teeth
- ☐ Grind teeth
- ☐ Clench teeth
- ☐ Growths or sore spots in your mouth
- ☐ Gums swollen, tender or bleeding
- ☐ Head, neck, TMJ/jaw pain, or aches
- ☐ Loose teeth or broken fillings
- ☐ Missing permanent teeth
- ☐ Mouth breathing
- ☐ Nitrous oxide
- ☐ Orthodontic treatment
- ☐ Periodontal treatment
- ☐ Sensitivity to pressure or irritants *(cold, heat, sweets)*
- ☐ Smokeless tobacco
- ☐ Do you currently smoke or have you smoked? Check applicable options below:
  - ☐ Occasionally/Light ☐ Average
  - ☐ Heavy ☐ Ex-Smoker
- ☐ Do you have a history or sleep apnea or snoring?
- ☐ Any injuries to face, mouth or teeth? If Yes, please explain: _____
- ☐ Have you ever had trouble from previous dental care? If Yes, please explain: _____
- ☐ Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? If Yes, please explain: _____
- ☐ How often do you floss? _____
- ☐ How often do you brush? _____
- ☐ Do you premedicate prior to dental treatment?

Additional questions for patients under 14:

- ☐ ADHD/ADD
- ☐ Immunizations are current
- ☐ Frequent bottle use/Sleeps with bottle at night
- ☐ Frequent sores on lips or mouth
- ☐ Nail biting
- ☐ Thumb, finger, or lip sucking or biting habit(s)
- ☐ Local anesthetic has been administered previously
- ☐ Reached puberty

Medical History

Physician's name _____ Physician's phone # _____ Date of last visit _____

Please check if you have/had:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial joints
- ☐ Birth control
- ☐ Blood disease
- ☐ Bone disorders
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Clotting disorders, and/or prolonged bleeding
- ☐ Cortisone treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Endocrine problems
- ☐ Epilepsy/Seizures
- ☐ Fainting or vertigo
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Heart, artificial valves
- ☐ Heart, mitral valve prolapse
- ☐ Hepatitis *(select type from below)*
  - ☐ A ☐ B ☐ C
- ☐ Herpes
- ☐ High blood pressure
- ☐ Immune deficiency *(including HIV/AIDS)*
- ☐ Jaundice/Other liver problem
- ☐ Kidney disease
- ☐ Low blood pressure
- ☐ Nursing
- ☐ Osteoporosis/Osteopenia
- ☐ Pacemaker
- ☐ Pregnant, due date: _____
- ☐ Radiation treatments
- ☐ Respiratory disease
- ☐ Rheumatic fever/disease
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Sleep study/CPAP
- ☐ Sickle cell anemia
- ☐ Skin rash
- ☐ STD/STI
- ☐ Stroke
- ☐ Swelling of feet/ankles/joints
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tonsils removed? Date: _____
- ☐ Tuberculosis *(TB)*
- ☐ Tumor or growth on head/neck
- ☐ Ulcer
- ☐ Weight loss, unexplained
- ☐ Have you had any blood transfusions? Approximate dates: _____
- ☐ Do you consume alcoholic beverages?
- ☐ Are you currently under the care of a Physician?
- ☐ Do you have a history of substance abuse?
- ☐ Have you ever had surgery? Approximate date of last surgery: _____
- ☐ Are you allergic or sensitive to latex?
- ☐ Do you have any allergies? *(Select one or more)*:
  - ☐ Hay fever, sinusitis
  - ☐ Nickel
  - ☐ Nuts
  - ☐ Other, please specify: _____
- ☐ Do you have Asthma?
  - ☐ Required hospitalization
  - ☐ Used steroids
  - ☐ Date of last episode: _____
- ☐ Are you currently taking any medications? If yes, please list: _____
- ☐ Any other medical conditions or concerns? _____

MedHX Notes (OFFICE USE ONLY)

Authorization and Release

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____

DENTAL & MEDICAL HEALTH HISTORY