Patient Registration

PATIENT INFORMATION

First Name		Last Name		Birth Date	
Address		City		State		Zip Code	
Status	❑ Child ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated	Gender	❑ Male ❑ Female
Home Phone		Cell Phone		Work Phone	
Email		Social Security #	
Employer		Occupation	
Address		City		State		Zip Code	
School		Grade	
Address		City		State		Zip Code	
Referred by	

IF MINOR, GUARDIAN INFORMATION / IF NOT MINOR, SPOUSE INFORMATION

First Name		Last Name		Birth Date	
Social Security #		Cell Phone		Work Phone	
If minor, are parents divorced?	❑ Yes ❑ No	Which parent does child live with?	❑ Mother ❑ Father

IN CASE OF EMERGENCY – WHO WOULD YOU LIKE US TO CONTACT

First Name		Last Name	
Phone #		Relationship	

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Name of Insured	First Last		
Birth Date		Social Security #	
Relationship to Patient			
Employer		Phone #	
Address			
City		State		Zip Code	
Insurance Co.		Phone #	
Address			
City		State		Zip Code	
ID #		Group #	

SECONDARY DENTAL INSURANCE

Name of Insured	First Last		
Birth Date		Social Security #	
Relationship to Patient			
Employer		Phone #	
Address			
City		State		Zip Code	
Insurance Co.		Phone #	
Address			
City		State		Zip Code	
ID #		Group #	

MEDICAL HISTORY

FOR WOMEN ONLY

Are you pregnant or think you are pregnant?	❑ Yes ❑ No	If yes, how many weeks/months?	
Are you on any special care for the pregnancy?	❑ Yes ❑ No	Please explain:	
Are you nursing?	❑ Yes ❑ No	Are you taking birth control pills?	❑ Yes ❑ No

ALLERGIES - Are you allergic to or have you had any reactions to the following?

	Yes	No		Yes	No		Yes	No
Aspirin			Codeine			Dental Anesthetics		
Erythromycin			Jewelry			Latex		
Metals			Penicillin			Tetracycline		

Please list any other allergy or reaction that is not listed above:

MEDICATIONS

Have you ever taken Bisphosphonates?				❑ Yes ❑ No	
If so, which one?		For how long?		Oral or IV?	
Are you on any type of Blood Thinner (aspirin, Coumadin, warfarin, Plavix, clopidogrel)?				❑ Yes ❑ No	
If so, write for what condition and what medication you take:					
Please list all medications, over the counter and herbal supplements, that you are currently taking including dosage:					

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding			Fever Blisters			Pacemaker		
Allergies			Frequent Headaches			Pneumocystitis		
Arthritis			Glaucoma			Psychiatric Problems		
Artificial Heart Valve			Hay Fever			Radiation Therapy		
Asthma			Heart Attack			Rheumatic Fever		
Blood Transfusion			Heart Surgery			Seizures		
Cancer – Chemotherapy			Hemophilia			Shingles		
Colitis			Hepatitis A			Sickle Cell Disease		
Congenital Heart Defect			Hepatitis B			Sinus Problems		
Cosmetic Surgery			High Blood Pressure			Stroke		
Diabetes			HIV+ / AIDS			Thyroid Problems		
Difficulty Breathing			Kidney Problems			Tuberculosis		
Drug Abuse			Liver Disease			Ulcers		
Emphysema			Low Blood Pressure			Venereal Disease		
Epilepsy			Mitral Valve Prolapse			Yellow Jaundice		
Fainting Spells								
Artificial Bones			Please specify					

Is there any disease, condition or problem that you think our office should know about that is not listed above? If so, please explain below.			❑ Yes ❑ No
Have you had any recent surgeries?			❑ Yes ❑ No
If so, please explain:			
Do you have or have you ever had any type of addiction?			❑ Yes ❑ No
If so, please explain:			
Are you under the care of a physician for any condition?			❑ Yes ❑ No
If so, write for what condition and what medication you take:			
Physician Name		Phone #	
Physician Name		Phone #	

DENTAL HISTORY

Do you have any present dental complaints?	❑ Yes ❑ No	What?	
When was your last full-mouth x-ray taken?		Where?	
When was your last cleaning?		Where?	
Have you ever been instructed in the prevention of decay?			❑ Yes ❑ No
Have you ever been instructed in caring for your gums?			❑ Yes ❑ No
Do you like the appearance of your teeth; your smile?			❑ Yes ❑ No
If not, please explain:			
Are your teeth all in alignment (straight)?			❑ Yes ❑ No
What would you like to change the most in the appearance of your teeth?			

Do you like the color of your teeth?			❑ Yes ❑ No
If not, please explain:			
Are your teeth:	❑ Chipped	❑ Protruding	❑ Hidden
Are your teeth wearing on the biting surfaces?			❑ Yes ❑ No
If yes, please explain:			
Are you concerned with your finances required to return your teeth to excellent dental health?			❑ Yes ❑ No
Do you get frustrated because you always have something to be treated/repaired when you visit the dentist?			❑ Yes ❑ No
Do you have dental fears?	❑ Yes ❑ No	What?	

FORM COMPLETION

I consent to treatment with the use of local anesthetic and/or Nitrous Oxide. To the best of my knowledge, all of the answers are true and correct. If I ever have any changes in my health or changes in my medications or other records, I will inform the Dentist/Assistant on my next appointment.

I also agree to assume full financial responsibility for all treatment rendered.

Signature of Patient, Parent or Legal Guardian		Date	

IF PATIENT IS A MINOR

Form signed by		Relationship to Patient	