PATIENT REGISTRATION

Patient's Name **Birth date** **Age** **Sex: M F**

Home Address	**City**	**State**	**Zip**

Home Phone #	***YOUR E-mail address*** **Your Soc Sec #**
Work Phone #	
YOUR cell phone #	**YOUR Driver's License Number** **(is not necessary if you are paying at the time of service)**

Your Place of Employment: **Your Occupation**

Please Circle One: Single Married Separated Widow

If patient is minor, we need:

Mother's Name & Birth date

Father's Name & Birth date

Person paying this bill:

Name of spouse (or parent if minor):

Spouse's (or parent's) employer **Spouse's Soc. Sec. #** **Work phone #**

EMERGENCY INFORMATION

Name, Address, & Telephone of
A relative not living with you:

Family Physician: **Phone Number:**

How did you hear about our office?

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's name

Date of Birth **Soc. Sec. #**

Insured's employer

Insurance Co

Insurance Co Address

Phone #

Group # **Policy #**

Patient Signature (or Parent of Child) **Date** **Dentist's Signature**

PATIENTS NAME:_____

DENTAL HISTORY

What is the most important thing to you about your dental visit today?

Five years from now, what would you like your dental health to look and feel like?

Please check the following:	**YES**	**NO**
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Mouth ulcers or cold sores	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Headaches, earaches, neck aches or -Jaw joint pain	☐	☐
-Bad breath	☐	☐
-Snoring	☐	☐
Do you have, or have you had any of the following?		
-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Gum treatments	☐	☐

Please share the following dates:

-Your last cleaning ___ / ___

-Your last oral cancer screening ___ / ___

-Your last complete X-Rays ___ / ___

Name of Previous Dentist:

City **State**

Why did you leave your previous dentist?

	YES	**NO**
Do you smoke or use chewing tobacco or Vape? How much? For how long?	☐	☐
If I could change my smile, I would:		
-Make my teeth whiter	☐	☐
-Make my teeth straighter	☐	☐
-Close spaces	☐	☐
-Replace metal fillings with tooth colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Have a smile makeover	☐	☐
-If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Please check any of the following that apply to you:

Y N	**Y N**	**Y N**	**Y N**
☐ ☐ Allergies (Seasonal)	☐ ☐ Emphysema	☐ ☐ Osteoporosis	☐ ☐ Ulcers
☐ ☐ Anemia	☐ ☐ Fainting	☐ ☐ Jaundice	☐ ☐ Other:
☐ ☐ Arthritis	☐ ☐ Glaucoma	☐ ☐ Jaw Joint Pain	
☐ ☐ Artificial Joints	☐ ☐ Head Injuries	☐ ☐ Pacemaker	
☐ ☐ Artificial Heart Valve	☐ ☐ Heart Disease	☐ ☐ Pre-Medication	
☐ ☐ Asthma	☐ ☐ Heart Conditions	☐ ☐ Radiation (head/neck)	**For WOMEN Only**
☐ ☐ Back Problems	☐ ☐ Heart Murmur	☐ ☐ Respiratory Problems	☐ ☐ Birth Control Pills
☐ ☐ Cancer	☐ ☐ other Heart conditions	☐ ☐ Seizures	☐ ☐ Breast-feeding
☐ ☐ Chemotherapy	☐ ☐ Hepatitis A B C	☐ ☐ Stomach Problems	☐ ☐ Pregnant
☐ ☐ Circulatory Problems	☐ ☐ High Blood Pressure	☐ ☐ Stroke	☐ ☐1-3 mos,3-6 mos,6-9mos,
☐ ☐ Diabetes	☐ ☐ Low Blood Pressure	☐ ☐ Swelling – Feet/Ankles	

☐ ☐ Dizziness ☐ ☐ Kidney Disease ☐ ☐ Thyroid Disease
☐ ☐ Excessive Bleeding ☐ ☐ Liver Disease ☐ ☐ Tuberculosis

Do you have any of the following drug allergies?

☐ ☐ Aspirin ☐ ☐ Ibuprofen ☐ ☐ Sulfa ☐ ☐ Other
☐ ☐ Codeine ☐ ☐ Latex ☐ ☐ Tetracycline
☐ ☐ Erythromycin ☐ ☐ Penicillin ☐ ☐ Tylenol

Patients Name:

Are you under a physician's care ☐ **Yes** ☐ **No** *If yes for what?*

Physicians Name & Phone number:

Preferred Pharmacy:

What medications are you currently taking?

Patient Signature (or Parent of Child) **Date** **Dentist's Signature**