Registration and History

Patient Information

Today's Date: ________________

Patient's Name: ______________________________ Patient's Birthdate: ________________

Patient's Social Security Number: ________________________ Patient's Sex: ☐ Male ☐ Female

Patient's Address: ______________________________ Town / City: ____________________

State: _____ Zip: ____________

Patient's Contact Information: Home Phone: ____________________ Work Phone: ________________

Cell: ______________ Email: __________________________ Other: ________________

Patient's Employer: ____

Employer's Address: ____

Patient's Status: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced

**** Whom may we thank for referring you? __________________________________

Account Responsibility

Who is responsible for this account? __________________ SS# ______________ Birthdate __________

Address __________________________________ City ________________ State _____ Zip _________

Phone #'s: H: _______________ W: _______________ Relationship to patient ____________________

Employer ________________________ Employer Address ____________________________________

Insurance Company _____________________________ Plan name / type __________________________

Ins. co. phone # ______________ Group # _____________ Is additional dental ins. involved? ☐ Yes ☐ No

Dental History ***_*** DO NOT DRAW LINES THRU BOXES: CHECK INDIVIDUALLY!!!_***

Reason for today's visit ______________________________ Former Dentist ________________________

Date of last visit ________________ City/State __________________________________

Please mark each box below individually to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
Bad breath	☐	☐	Bleeding gums	☐	☐	Blisters on lip or mouth	☐	☐
Click or pop in jaw	☐	☐	Dry mouth	☐	☐	Fingernail biting	☐	☐
Habitual placement of objects in teeth/mouth	☐	☐	Burning sensation on tongue	☐	☐	Chew on one side of mouth	☐	☐
Smoke	☐	☐	Grind teeth	☐	☐	Swollen / tender gums	☐	☐
Jaw pain, tiredness	☐	☐	Lip or cheek biting	☐	☐	Loose teeth	☐	☐
Broken fillings	☐	☐	Mouth breathing	☐	☐	Pain when brushing	☐	☐
Orthodontic treatment	☐	☐	Periodontal treatment	☐	☐	Hot / cold sensitivity	☐	☐
Sensitivity to sweets	☐	☐	Sensitivity when biting	☐	☐	Sores / growths in mouth	☐	☐

How often do you floss? _______________ How often do you brush? __________________

Medical History ***_DO NOT DRAW LINES THRU BOXES: CHECK INDIVIDUALLY!!!_**

Physician's name ______________________________ Town, State ________________________ Last Visit ________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yes	No		Yes	No		Yes	No
AIDS	☐	☐	Epilepsy	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Fainting or dizziness	☐	☐	Scarlet Fever	☐	☐
Arthritis, Rheumatism	☐	☐	Glaucoma	☐	☐	Shortness of Breath	☐	☐
Artifical Heart Valves	☐	☐	Headaches	☐	☐	Sinus Trouble	☐	☐
Artificial Joints	☐	☐	Heart Murmur	☐	☐	Skin Rash	☐	☐
Asthma	☐	☐	Heart Problems	☐	☐	Special Diet	☐	☐
Back Problems	☐	☐	Hepatitis: Type _____	☐	☐	Stroke	☐	☐
Bleeding abnormally with extractions	☐	☐	Herpes	☐	☐	Swelling of ankles or feet	☐	☐
			High blood pressure	☐	☐			
Blood disease	☐	☐	HIV Positive	☐	☐	Swollen neck glands	☐	☐
Cancer	☐	☐	Jaundice	☐	☐	Thyroid Problems	☐	☐
Chemical Dependency	☐	☐	Jaw Pain	☐	☐	Tonsillitis	☐	☐
Chemotherapy	☐	☐	Kidney Disease	☐	☐	Tumor or growth on head or neck	☐	☐
Circulatory problems	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Congenital Heart Lesion	☐	☐	Low Blood Pressure	☐	☐	Ulcer	☐	☐
			Mitral Valve Prolapse	☐	☐	Unexplained weight loss	☐	☐
Cortisone Treatments	☐	☐	Nervous Problems	☐	☐			
Cough, persistent or bloody	☐	☐	Pacemaker	☐	☐	Venereal Disease	☐	☐
Diabetes	☐	☐	Psychiatric Care	☐	☐	Women:		
Emphysema	☐	☐	Radiation Treatment	☐	☐	Are you pregnant	☐	☐
Do you wear contact lenses	☐	☐	Respiratory Disease	☐	☐	Are you nursing	☐	☐

Medications

- Do you take any bisphosphonates? Yes ☐ No ☐
- List all medications you are currently taking:

________________________ ________________________
________________________ ________________________
________________________ ________________________
________________________ ________________________

Allergies

☐ Aspirin
☐ Barbituates
☐ Codeine
☐ Iodine
☐ Other:
☐ Local anesthetic
☐ Penicillin
☐ Sulfa
☐ Latex

________________________ ________________________
________________________ ________________________

Certification

I hereby certify that all of the information provided on this form is as complete and accurate as possible.

________________________________ ______________
Signature Date

Doctor Review

________________________________ ______________
Signature Date

In Case of An Emergency:

Who should we contact?

Name ________________________________

Relationship ________________________________
Home phone # ________________________________
Work phone # ________________________________
Additional Phone # ________________________________