

# *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	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Blisters on lip or mouth	<input type="checkbox"/>	<input type="checkbox"/>
Click or pop in jaw	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Fingernail biting	<input type="checkbox"/>	<input type="checkbox"/>
Habitual placement of objects in teeth/mouth	<input type="checkbox"/>	<input type="checkbox"/>	Burning sensation on tongue	<input type="checkbox"/>	<input type="checkbox"/>	Chew on one side of mouth	<input type="checkbox"/>	<input type="checkbox"/>
Smoke	<input type="checkbox"/>	<input type="checkbox"/>	Grind teeth	<input type="checkbox"/>	<input type="checkbox"/>	Swollen / tender gums	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain, tiredness	<input type="checkbox"/>	<input type="checkbox"/>	Lip or cheek biting	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Broken fillings	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	Pain when brushing	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>	Hot / cold sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to sweets	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity when biting	<input type="checkbox"/>	<input type="checkbox"/>	Sores / growths in mouth	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally with extractions	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles or feet	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Swollen neck glands	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growth on head or neck	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesion	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cough, persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>	Women:		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>			
			Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>			

## Medications

- Do you take any bisphosphonates? Yes  No

- List all medications you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Allergies

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Aspirin     | <input type="checkbox"/> Local anesthetic |
| <input type="checkbox"/> Barbituates | <input type="checkbox"/> Penicillin       |
| <input type="checkbox"/> Codeine     | <input type="checkbox"/> Sulfa            |
| <input type="checkbox"/> Iodine      | <input type="checkbox"/> Latex            |
| <input type="checkbox"/> Other:      |   |

\_\_\_\_\_

\_\_\_\_\_

## 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 # \_\_\_\_\_