

PATIENT REGISTRATION

Please present your Driver's License and Dental Insurance Card to the receptionist.

Marital Status: Single Married Divorced Separated Widowed

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Preferred Name / Nickname: _____ **Sex:** Male Female

Date of Birth: ____ / ____ / _____ **Age:** ____ **Social Security #:** ____ - ____ - _____

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

Home #: ____ - ____ - _____ **Work #:** ____ - ____ - _____ **Ext.:** ____ **Cell #:** ____ - ____ - _____

Email address: _____ **Drivers License #:** _____ **Driver's License State:** _____

I would like to receive appointment reminders via (check all that apply): Mail Text Email

Responsible Party (if someone other than the patient)

First Name: _____ **Last Name:** _____ **Middle Initial:** ____ **Sex:** Male Female

Date of Birth: ____ / ____ / _____ **Age:** ____ **Social Security #:** ____ - ____ - _____

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

Home #: ____ - ____ - _____ **Work #:** ____ - ____ - _____ **Ext.:** ____ **Cell #:** ____ - ____ - _____

Email address: _____ **Drivers License #:** _____ **Driver's License State:** _____

PRIMARY INSURANCE INFORMATION

Name of Policy Holder: _____ **Relationship to Patient:** Self Parent Spouse Other

Policy Holder's Social Security #: ____ - ____ - _____ **Policy Holder's DOB:** ____ / ____ / _____

Member / Policy / Carrier ID: _____ **Employer ID / Group #:** _____

Employer Name: _____

Address: _____

Address 2: _____

City: _____ **State:** _____ **Zip:** _____

Occupation: _____

Employment Status: Full-Time Part-Time Retired

Insurance Company Name: _____

Address: _____

Address 2: _____

City: _____ **State:** _____ **Zip:** _____

Contact Number: ____ - ____ - _____

Annual Maximum: _____ **Annual Deductible:** _____

Remaining Benefits: _____

If you currently have Secondary Insurance Coverage, please complete the back of this form.

SECONDARY INSURANCE INFORMATION

Name of Policy Holder: _____ Relationship to Patient: Self Parent Spouse Other

Policy Holder's Social Security #: _____ - _____ - _____ Policy Holder's DOB: ____ / ____ / _____

Member / Policy / Carrier ID: _____ Employer ID / Group #: _____

Employer Name: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employment Status: Full-Time Part-Time Retired

Insurance Company Name: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Contact Number: _____ - _____ - _____

Annual Maximum: _____ Annual Deductible: _____

Remaining Benefits: _____

MEDICAL HISTORY

Patient Name _____

Birth Date ____ / ____ / _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

| | |
|---|---|
| <p>Are you allergic to any of the following?</p> <p> <input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Acrylic <input type="checkbox"/> Metal <input type="checkbox"/> Latex <input type="checkbox"/> Local Anesthetics <input type="checkbox"/> Other </p> <p>If other, please explain: _____</p> | <p>Women: Are you...</p> <p> <input type="checkbox"/> Pregnant / Trying to get pregnant? <input type="checkbox"/> Nursing? <input type="checkbox"/> Taking oral contraceptives? </p> |
|---|---|

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

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores / Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack / Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis / Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach / Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble / Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells / Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No

If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT / PARENT / GUARDIAN _____ DATE ____ / ____ / _____

Welcome to our practice! This confidential information will help us prepare for your visit.

Name _____

Why have you made this dental appointment?

Who may we thank for referring you to our office?

Why did you leave the office of your previous dentist?

Please check one box in each section.

- My mouth is very comfortable.
- My mouth is moderately comfortable.
- My mouth is uncomfortable.

- I think the appearance of my smile is excellent.
- I am satisfied with the appearance of my smile.
- I would like to change my smile.
- I am unconcerned about the appearance.

- I will do whatever I must to keep my teeth.
- I want to keep my teeth but only within a certain budget of time and money.
- I am indifferent about keeping my teeth.

- I have always done what was recommended to me.
- I have not done what was recommended to me.
- I have not had dentistry recommended to me.

- I put dental care for myself and family high on my list.
- I put dental care low on my list.
- I have never considered where I put dental care.

- I think my present state of dental health is excellent.
- I think my present state of dental health is good.
- I think my present state of dental health is poor.

Are you having any discomfort or pain? Y / N

How long has it been since your last dental visit? _____

What dental problems are you experiencing?

Do you have any popping or clicking noises in your ears when you chew, open or move your mouth? Y / N

Have you ever experienced difficulty in achieving complete anesthesia? Y / N

If by magic you could change your smile or teeth, what changes would you like?

Obstacles I see to having excellent dental care for myself...

If you select more than one of the following, please number them in order of significance with #1 being that which is most significant for you at this time.

- _____ I see no obstacles
- _____ Time away from work or other obligations
- _____ Fear of pain, surgery, or injections
- _____ Fear because of past dental experiences
- _____ Cost of treatment
- _____ Other _____