WELCOME

PATIENT REGISTRATION

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

PATIENT INFORMATION

Name: ______________________________ Date: ______________

Name you prefer to be called ______________________ Referred by ______________________

Social Security # ______________________ Date of Birth ______________________

If you are a minor, name of parent(s) ______________________________

Full time student ( ) yes ( ) no. If YES, name of school ______________________

Mailing address: ______________________________

City ____________ State ________ Zip Code __________ Home Phone: ( ) ____________

If you can be contacted at work, phone no. ( ) ______________ ext. ______________

Cell phone ( ) ______________

PERSON RESPONSIBLE FOR ACCOUNT

if not same as above

Name ______________________________

Mailing Address ______________________________

City ____________ State ________ Zip Code __________ Home Phone: ( ) ____________

Work Phone: ______________________ Cell Phone: ______________________

EMPLOYER/INSURANCE INFORMATION

Insured's Name ______________________ Date of Birth ______________

Address ______________________________

Employer ______________________ Address ______________________

Primary Insurance Company ______________________________

I.D. # ______________________ Group # ______________________

Secondary's Insured's Name ______________________ Date of Birth ______________

Address ______________________________

Secondary Insurance Company ______________________________

I.D. # ______________________ Group # ______________________

EMERGENCY INFORMATION

Local Relative or Friend:

Name ______________________ Relationship to Patient ______________

Phone: ______________________

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and insurance carrier and not the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payment received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred.

MEDICAL HISTORY

Patient's Name ____________________________________

1. Physician's Name ____________________________________ Phone No. ____________________________
2. Are you presently taking any prescription or over the counter medications? Please list below.

____

____

3. Are you aware of having an allergic (or adverse reaction) to any medication or substance: .... ☐ Yes ☐ No

   If yes, please list: ____

   ____

4. Have you been a patient in the hospital during the past five years? .... ☐ Yes ☐ No
5. Indicate which of the following you have had, or have at present. Please Circle either Yes or No.

Congenital Heart Disease/Malformation	Yes	No
Heart Murmur	Yes	No
Mitral Valve Prolapse w/ regurgitation	Yes	No
Artificial Heart Valve	Yes	No
Rheumatic Fever	Yes	No
Artificial Joints	Yes	No
Previous Bacterial Endocarditis	Yes	No
Surgically Constructed Systemic/ Pulmonary Shunts	Yes	No
Hypotrophic Cardiomyopathy	Yes	No

If you have indicated "Yes" to any of the occurrences in this box, please call our office prior to your first visit.

Angina/Chest Pain	Yes	No
Heart Pacemaker	Yes	No
Heart (Surgery, Disease, Attack)	Yes	No

Dates of Occurrences: ______________

____

____

____

Stroke	Yes	No
Diet (Special/Restricted)	Yes	No
Kidney Trouble	Yes	No
Ulcer	Yes	No
Diabetes	Yes	No
Thyroid Problems	Yes	No
Glaucoma	Yes	No
Cancer	Yes	No
Emphysema	Yes	No
Chronic Cough	Yes	No
Tuberculosis	Yes	No
Asthma	Yes	No
Hay Fever	Yes	No
Latex Sensitivity	Yes	No
Allergies or Hives	Yes	No
Sinus Trouble	Yes	No
Radiation Therapy	Yes	No
Chemotherapy	Yes	No
Low Blood Pressure	Yes	No
High Blood Pressure	Yes	No

Tumors	Yes	No
Hepatitis A (infectious) B (serum) ...	Yes	No
Venereal Disease	Yes	No
A.I.D.S.	Yes	No
H.I.V. Positive	Yes	No
Cold Sores/Fever Blisters	Yes	No
Blood Transfusion	Yes	No
Hemophilia	Yes	No
Sickle Cell Disease	Yes	No
Bruise Easily	Yes	No
Liver Disease	Yes	No
Yellow Jaundice	Yes	No
Neurological Disorders	Yes	No
Epilepsy or Seizures	Yes	No
Fainting or Dizzy Spells	Yes	No
Nervous/Anxious	Yes	No
Radiation Therapy	Yes	No
Psychiatric/Psychological Care .	Yes	No
Arthritis/Rheumatism	Yes	No
Cortisone Medication	Yes	No

6. Do you use more than two pillows to sleep? .... ☐ Yes ☐ No
7. Have you lost or gained more than 10 pounds in the past year? .... ☐ Yes ☐ No
8. Do you have or have you had any disease, condition or problem not listed? .... ☐ Yes ☐ No

   If yes, please list ____

9. Women: Are you **Pregnant?** ☐ Yes ____ Months ☐ No **Nursing:** ☐ Yes ☐ No **Taking Birth Control Pills?** ☐ Yes ☐ No

Comments: ____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I hereby give consent for dental treatment. I will discuss any questions concerning treatment and fees with the dentist.

Parent/Guardian Signature: ______________________________________ Date: ________________

Patient Name	Date

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care
please complete this dental history form.
All information is completely confidential.

What is the reason for your visit today? ______________________

____

Date of Last Dental Visit ____________ **Last Dental Cleaning** ____________ **Last Full Mouth X-rays** ____________

What was done at your last dental visit? ______________________

____

Previous Dentist's Name ______________________

Address: ______________________ State ________ Zip ________ Phone ____________

How often do you have dental examinations? ______________________

How often do you brush your teeth? ____________ How often do you floss? ____________

What other dental aids do you use? (Interplak, toothpick, etc.) ____________

Do you have any dental problems now? Yes No

If yes, please describe ______________________

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweet?	Yes	No
Biting or chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently have cold sores, blisters or any other oral lesions?	Yes	No

Do your gums bleed or hurt?

Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? ____________

Do you

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lip or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause ____________

____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Is there anything you would like to change about your smile?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe ______________________

____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe ______________________

____

____