PATIENT REGISTRATION Date_____

First Name_____ MI_____ Last Name_____

Nickname_____ Sex: Male Female

Marital Status *(Please Circle One)* Married Single Divorced Widowed Life Partner

Address_____

City_____ State_____ Zip_____

Phone #_____Cell # _____

Email_____

Birth Date_____ Age_____ SSN_____

Occupation _____

PRIMARY INSURANCE CARRIER

Insurance Company _____Insured's ID # or SSN_____

Insured's Name_____Birth Date_____

Employer Name_____Relationship to Patient_____

SECONDARY INSURANCE CARRIER

Insurance Company _____Insured's ID # or SSN_____

Insured's Name_____Birth Date_____

Employer Name_____Relationship to Patient_____

ACCOUNT INFORMATION: PERSON FINANCIALLY RESPONSIBE FOR ACCOUNT

Name _____Relationship to Patient_____

SSN_____ Phone # _____

Address_____

City_____ State_____ Zip _____

GETTING TO KNOW YOU:

Is another member of your family or relative a patient at our office?

Name:_____Relationship:_____

How did you learn of our office? *(Please Circle One)* **Friend Family Internet Other_____**

If a friend or family member referred you to our office, we would like to be able to say thank you.

You were referred by: _____

Person to Contact in Case of Emergency:_____

Phone #_____Cell #_____

*In order for us to help remind you of your appointments and/or notify you of last minute openings in the hygiene/ treatment schedule, we would like to know how you would prefer us to contact you. If you could please **check** next to the service you desire, we would appreciate it. If you check more than one please put an asterisk (*) next to the option you would desire first.*

__ Phone call Phone #_____

__Text message Cell # _____

__ E-mail E-mail_____

__ Automated phone call in which you have to push a button to confirm or cancel.

Would you like to be placed on our quick call list (using the preferred method of contact from above) if an earlier appointment opens up around the time you are already scheduled (treatment or hygiene appointment)? **YES** **NO**

DENTAL HISTORY

What is the reason for your visit today?_____

Are you satisfied with your teeth's appearance? **YES** **NO** *If No, what would you change*?_____

Date of your last*: Dental Visit*?_____ *Dental Cleaning*?_____ *Dental x-rays*? _____

How often did you have dental exams?_____

Would you like us to contact your previous dentist to obtain your previous x-rays or records? If so, please provide the following information:

Previous Dentist Name_____ City and State_____

How often do you: B*rush Your Teeth*?_____F*loss*?_____

What dental aids do you use? *(floss, toothpicks, etc.)*_____

Do you use fluoride products? *(Please Circle One)* **YES** **NO**

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*Please Circle Yes **(Y)** or No **(N)** For the Following Questions:*

Are your teeth sensitive to:

Hot or Cold? **Y** **N** Sweets? **Y** **N** Biting or Chewing? **Y** **N**

Y **N** Have you noticed any mouth odors or bad tastes?

Y **N** Do you frequently get cold sores, blisters or any other lesions on your lips or in your mouth?

Y **N** Have you noticed any loose teeth or change in your bite?

Y **N** Does food tend to get caught in between your teeth?

If yes, where?_____

Y **N** Do you feel nervous/apprehensive about dental treatment? *If Yes, why?*_____

Y N Would you like to discuss, with the doctor, the use of oral sedation for your dental treatment?

Do You?

Y N Clench or grind your teeth while awake or asleep?

Y N Have tired jaws, especially in the morning?

Y N Snore or have any other sleeping disorders?

Y N Hold foreign objects with your teeth? *(Pencils, fingernails, pens, candies, etc?)*

Have you ever had:

Y N Orthodontic treatment?

Y N Oral Surgery?

Y N Periodontal Surgery?

Y N Wear a night guard or mouth guard?

Y N A serious injury to your mouth or head?

Have you ever experienced:

Y N Clicking or popping in the jaw?

Y N Difficulty opening or closing your mouth?

Y N Headache, neck aches or shoulder aches?

HEALTH HISTORY

Your answers are for our records only and will be kept confidential. Please note that during your initial visit our team may ask additional questions concerning your responses.

Date of last health exam?_____ What was this exam for?_____

Y N Have you been hospitalized in the last 5 years? *If yes, please explain*:_____

Y N Are you currently receiving medical care? *If yes, what is the nature of care*?_____

Please Circle Yes (Y) or No (N) for the following:

Y N Hypertension (*High Blood Pressure*)

Y N Congestive Heart Failure

Y N Abnormal Heart or Previous Bacterial Endocarditis

Y N Congenital Heart Disease

Y N Heart Disease, Heart Attack, Heart Surgery

Y N Heart Valve (artificial)/ Heart Transplant

Y N Heart Stent

If yes, when?_____

Y N Stroke

If yes, when?_____

Y N Rheumatic Fever

Y N Abnormal Bleeding

If yes, do you take blood thinners and why?_____

Y N Anemia or Blood Disorder

Y N Cancer or Tumor

Y N Sore/Enlarged Lymph Nodes

Y N Radiation/Chemotherapy Treatment

Y N Slow Healing Mouth Sores

Y N Unintentional Weight Loss/Gain

Y N Asthma

Y N Emphysema or Other Respiratory/Lung Disease

Y N Diabetes

Y N Gout

Y N HIV Infection/AIDS

Y N Venereal Disease

Y N Arthritis, Rheumatism/Other Inflammatory Disease

Y N Joint Replacement

If yes, when?_____

Y N Epilepsy

Y N Fainting or Dizzy Spells

Y N Psychiatric Problems

Diagnosis?_____

Y N Glaucoma

Y N Liver Disease *(including jaundice)*

Y N Hepatitis *If yes, what form*?_____

Y N Kidney Disease

If yes, are you on dialysis? **Y N**

Are there any other conditions? If so, please list:_____

_____

Are you taking any of these medications?

Y N Pre-medication before dental treatment

Y N Antacids

Y N Tagamet (cimetidine) or Prilosec (omeprazole)

Y N Cardizem, Calan or Isoptin

Y N Dilantin or Tegretol

Y N Barbiturates (any)

Y N Serzone

Y N Diflucan or Spoonox

Y N Biaxin

Y N St. John's Wort or Kava-Kava

Y N Have you been treated with Bisphosphonate drugs? (Fosamax, Aredia, Zometa, Actonel, Boniva)

If yes, when did treatment begin?

_____

When did treatment end?_____

Y N Have you ever taken weight loss drugs (such as fen-phen)?

Y N Do you consume grapefruit juice, grapefruits, or grapefruit extract?

Please list any medications you are currently taking: _____

_____

_____

_____

Please list any dietary or herbal supplements you are taking and for what purpose: _____

_____

_____

_____

Are you allergic or have you had a reaction to:

Y N	Local anesthetics	**Y N**	Aspirin, Ibuprofen, or Tylenol	**Y N**	Valium
Y N	Penicillin or other antibiotics	**Y N**	Codeine	**Y N**	Latex
				Y N	Metals

Other:_____

Y N Do you use tobacco? If yes: what *type?*_____

*How much per day?*_____ *For how long?*_____ *Do you want to quit?* **Y N**

Y N Do you consume alcohol*?* *If yes, approximately how many beverages per week*? _____

Y N Do you use recreational drugs? *If yes, please list what drugs and how often you use them?* _____

_____

_____

WOMEN ONLY

Y N Are you pregnant?

If No, are you planning a pregnancy in the near future? **Y N**

Y N Are you nursing?

Y N Are you taking birth control?

I understand the above information is necessary to provide dental care in a safe and efficient manner for me. 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 change in my health and medications.

Patient (Print Name)	Patient Signature	Date

_____

Doctor (Print Name)	Doctor Signature	Date