PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Preferred Name:

Patient is : □ Responsible Party □ Policy Holder

Patient Information:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Sex: ○ Female ◉ Male Marital Status: ○ Married ◎ Single ◉ Divorced ◎ Separated ◎ Widowed

Birth date: Social Security #: Drivers Lic#:

E-mail:

Employment Status: ○ Full Time ○ Part Time ◉ Self Employed ○ Retired ○ Unemployed

Student Status: ◉Full Time ○ Part Time Name of School _____

Preferred Dentist:_____ Preferred Hygienist: _____

Preferred Pharmacy: _____

Referred By: _____

Responsible Party: (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip:

Home Phone: Work Phone: Cell Phone:

Birth date: Social Security #: Drivers Lic#:

○ Responsible Party is Policy Holder for Patient ◉ Primary Policy Holder ○ Secondary Policy Holder

Is the Responsible Party a Patient? No

Primary Insurance Information:

Name of Insured: Relationship to Insured: ○Self ○Spouse ◉Child ○ Other

Employer ID: Carrier ID:

Insured Social Security #: Insured Birth date:

Employer: Insurance Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Secondary Insurance Information:

Name of Insured:	Relationship to Insured: ○Self ☐Spouse ◉Child ☐ Other
Employer ID:	Carrier ID:
Insured Social Security #:	Insured Birth date:
Employer:	Insurance Company:
Address:	Address:
Address 2:	Address 2:
City, State, Zip:	City, State, Zip:

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

Women: Are you Pregnant/Trying to get pregnant? No Taking oral contraceptives? No Nursing? No

Are you allergic to any of the following? Check all that apply.

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

Other If yes, please explain:

Do you have, or have you had, any of the following Medical Conditions? Check All That Apply.

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

Have you ever had any serious illness not listed above? If yes, please explain: _____

_____

_____

Patient Dental History

Do your gums bleed while flossing No
Are your teeth sensitive to sweet/sour foods No
Do you feel pain to any of your teeth No
Do you have lumps/sores in/near your mouth No
Have you had any neck, head, jaw injuries No
Have you ever experienced any of the following problems in your jaw
Clicking. No ……. ….
Pain (joint, ear, face). No ….
Difficulty Opening/closing. No
Difficulty Chewing . No …….

Do you clench or grind your teeth No
Do you bite your lips/cheeks frequently No
Have you had difficult extractions in the past No
Have you had prolonged bleeding following extractions No
Have you had orthodontic treatment No
Do you wear dentures/partials No
Have you received oral hygiene instructions regarding your teeth/gums No
Do you like your smile No

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, or GUARDIAN _____ DATE _____