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PATIENT REGISTRATION

CONFIDENTIAL

PATIENT HISTORY

PATIENT'S NAME		BIRTH DATE		AGE	SEX
HOME ADDRESS		CITY	STATE	ZIP	HOME PHONE
NAME OF PATIENT'S EMPLOYER		ADDRESS		BUSINESS PHONE	
OCCUPATION		SOCIAL SECURITY #			
NAME OF SPOUSE		BIRTH DATE	SOCIAL SECURITY #		EMPLOYER
NAME OF PRIMARY DENTAL INSURANCE CO.			ADDRESS		
SUBSCRIBER NAME AND ID #				GROUP #	
NAME OF SECONDARY DENTAL INSURANCE CO.			ADDRESS		
SUBSCRIBER NAME AND ID #				GROUP #	
REFERRED TO OUR OFFICE BY					
MEDICAL DOCTOR		ADDRESS		DATE OF LAST VISIT	
FORMER DENTIST		ADDRESS		DATE OF LAST VISIT	
DATE OF LAST DENTAL X-RAYS		FULL MOUTH		BITEWINGS	

WHO IS RESPONSIBLE FOR THIS ACCOUNT

DENTAL HISTORY		YES	NO
1. Have you received proper toothbrushing instructions?	_____	_____	_____
2. How often do you brush?	_____	_____	_____
3. Have you received proper flossing instructions?	_____	_____	_____
4. How often do you use dental floss?	_____	_____	_____
5. Have you ever had an injection to numb your mouth for dental work?	_____	_____	_____
6. Have you ever had Nitrous Oxide (laughing gas) for dental work?	_____	_____	_____
7. Have you ever had any nasal obstructions?	_____	_____	_____
8. Do you have any unhealed injuries of inflamed areas in or around your mouth?	_____	_____	_____
9. Are you aware of any swelling or lumps in your mouth?	_____	_____	_____
10. Do you chew only on one side of your mouth?	_____	_____	_____
11. Do any of your teeth feel loose?	_____	_____	_____
12. Do you grind or chench your teeth?	_____	_____	_____
13. Do you have pain or clicking in your jaw joint when chewing or clenching?	_____	_____	_____
14. Do you have pain around your ears?	_____	_____	_____
15. Does food wedge between your teeth? if yes, what areas?	_____	_____	_____
16. Are your teeth sensitive to heat _____ cold _____ sweet _____ air _____ pressure _____	_____	_____	_____
17. Do you have an unpleasant taste in your mouth or had bad breath at times?	_____	_____	_____
18. Do your gums bleed?	_____	_____	_____
19. Have you ever had surgery on your gums? If yes, when? _____ Doctor's Name _____	_____	_____	_____
20. Have you ever had a serious accident involving head or jaw injuries?	_____	_____	_____
21. Have you ever had orthodontic treatment?	_____	_____	_____
22. Have you ever had root canal therapy?	_____	_____	_____
23. Have you ever had any extractions? If yes, date and reasons _____	_____	_____	_____
24. Did you have any complications with extractions? Excessive or prolonged bleeding? _____ Dry Socket? _____ Other? _____	_____	_____	_____
25. Have they been replaced by: Fixed Bridge? _____ When? _____ Removable Partial Denture? _____ When? _____ Full Dentures? _____ When? _____ Implants? _____ When? _____	_____	_____	_____
26. Have you been dissatisfied with any dental treatment in the past?	_____	_____	_____
27. Do you have fluoridated water?	_____	_____	_____

DATE _____

SIGNATURE _____

Parent or Guardian if patient is a minor

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

City State Zip:

Email:

Home Phone:

Work Phone:

Birth Date:

Social Security No.:

Marital Status:

Primary Dental Guarantor:

Home Phone:

Work Phone:

Secondary Dental Guarantor:

Home Phone:

Work Phone:

Physician Name:

Physician Phone:

Pharmacy:

Pharmacy Phone:

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y N

- Are you taking Birth Control Pills?
 Are you pregnant? If Yes, # of weeks
 Are you nursing?

Please answer the following:

Y N

- Do you smoke or use tobacco? Height:

For Office Use Only

- BP Heart Rate: Weight:

- | Y | N | Conditions |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina Pectoris |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Bones |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruise Easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer- Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defect |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches |

- | Y | N | Conditions |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV+ AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis C |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Pace Maker |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain In Jaw Joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumocystitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |

- | Y | N | Conditions |
|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Yellow Jaundice |
-
- | Y | N | Allergies |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> | Erythromycin |
| <input type="checkbox"/> | <input type="checkbox"/> | Jewelry |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Metals |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetracycline |
| Other | | |
| <hr/> | | |
| <hr/> | | |
| <hr/> | | |

Medications:

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Y N
 Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below...

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Notes:

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Signature: _____ Date: _____
(If Under 18, Parent or Guardian Signature Required)