



PATIENT REGISTRATION

Date _____

Name _____
Last First Middle

Address _____
Street City State Zip

Date of Birth _____ Social Security Number _____

Home Phone _____ Mobile Phone _____

Who should we contact in case of emergency? _____
Phone Number

Occupation _____ Employed By _____

Business Address _____
Street City State Zip

Business Phone _____ E-Mail _____

How would you like your appointment confirmed? mobile phone home phone
 work phone e-mail

Does this employer provide dental insurance? Yes No

Name of Dental Insurance _____ Group Number _____

Spouses Name _____
Last First Middle

Date of Birth _____ Social Security Number _____

Mobile Phone _____ Business Phone _____

E-Mail _____

Occupation _____ Employed By _____

Business Address _____
Street City State Zip

Does this employer provide dental insurance? Yes No

Name of Dental Insurance _____ Group Number _____

Referred By _____

APPOINTMENTS: A CHARGE WILL BE MADE FOR MISSED APPOINTMENTS OR CANCELLATIONS WITH LESS THAN 24-HOURS NOTICE. THIS TIME IS BEING RESERVED SPECIFICALLY FOR YOU.

Please complete other side ➡

DENTAL HISTORY

When was the last time you had your teeth cleaned? _____

Are you having any discomfort or pain in your mouth?..... Yes No

Are you displeased/unhappy with the appearance of your teeth? Yes No

Are you worried about receiving dental treatment..... Yes No

Would you like information about sedation? Yes No

Have you had any injuries to your mouth or teeth? Yes No

Do your gums bleed when you brush or floss? Yes No

Are you aware of clenching or grinding your teeth? Yes No

Do you get headaches often? Yes No

Are you aware of popping or clicking sounds when you chew?..... Yes No

Are your teeth sensitive to hot or cold?..... Yes No

Please add anything you feel is important for the doctor to know _____

MEDICAL HISTORY

General health (please check): Excellent Fair Poor

Name and address of physician _____

Are you under a physician's care now? Yes No

Are you taking any medication now? Yes No

If so, please list _____

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

Heart Problems Yes No

High Blood Pressure Yes No

Rheumatic Fever Yes No

Heart Murmur Yes No

Mitral Valve Prolapse Yes No

Circulatory Problems Yes No

Nervous/Mental Problems..... Yes No

Adrenal Insufficiency Yes No

Excessive Bleeding Yes No

Allergies to Anesthetics Yes No

If So, What? _____

Allergies to Medicines or Drugs .. Yes No

If So, What? _____

Other Allergies _____

Fainting Yes No

Other _____

Pacemaker Yes No

Stroke/Heart Attack..... Yes No

AIDS Yes No

Anemia or Blood Disorder..... Yes No

Kidney or Liver Problems Yes No

Arthritis Yes No

Asthma or Hay Fever Yes No

Diabetes..... Yes No

Hepatitis Yes No

Malignancies (tumors or growths) Yes No

Prosthesis/Joint Replacement Yes No

Herpes..... Yes No

Sinus Problems Yes No

Ulcers or Stomach Disorders..... Yes No

Epilepsy Yes No

Women-Are You Pregnant? _____ How Many Months? _____

Is there any other condition or problem that you think we should know about? _____

I, the undersigned, have answered the above questions as carefully as possible and understood each question being asked.

Patient Signature _____ Date _____