ROBERT E. DAY, DDS, FAGD

PATIENT REGISTRATION AND MEDICAL / DENTAL HISTORY

Committed To Excellence... Because We Care"

Medical Alert

Pharmacy Name _____ Phone _____

So that we may provide you with the best possible care, please complete both sides of this medical/dental history form.

(PLEASE PRINT)

Date _____ Whom may we thank for referring you? _____

Patient Name _____ (Preferred Name _____)

Home Phone _____ Work Phone _____ Cell/Pager _____ Email _____

Address _____

City _____ State _____ Zip _____ Social Security # _____ Driver's Lic.# _____

Sex: ☐ Male ☐ Female Age _____ Birthday ___/___/___ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed By _____

Occupation _____

Business Address _____

City _____ State _____ Zip _____ Tel. _____

Spouse Name _____ Birthday ___/___/___

Employed By _____

Business Address _____

City _____ State _____ Zip _____ Tel. _____

Social Security # _____

Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____

Hm# ( ) _____ DL# _____

Employer: _____

Wk# ( ) _____ Ext: _____ SS# _____

Dental Insurance Primary Carrier

Insured's Name _____ Social Security # _____

Insurance Company _____ Telephone _____

Address _____

City _____ State _____ Zip _____

Group Number _____ ID Number _____ Birthdate _____

Insured's Employer _____

Dental Insurance Secondary Carrier

Insured's Name _____ Social Security # _____

Insurance Company _____ Telephone _____

Address _____

City _____ State _____ Zip _____

Group Number _____ ID Number _____ Birthdate _____

Insured's Employer _____

DENTAL HISTORY

Circle "Yes" or "No" to each item.

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips 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
How much? _____		

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If yes please describe, including cause.		

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 get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or a change in your bite?	Yes	No
Do you have difficulty in chewing on either side of the mouth?	Yes	no
Does food tend to become caught in between your teeth?	Yes	No
If yes, where? _____		

Have you ever experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Headches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you happy with your smile?	Yes	No
Are you pleased with the color of your teeth?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If yes, what is your biggest concern?

_____

_____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe _____