REGISTRATION FORM

PATIENT INFORMATION

NAME: LAST_____ FIRST _____ MIDDLE INITIAL _____ BIRTH DATE: _____ AGE: _____
SEX: M / F MARITAL STATUS: S M D W SOC. SEC. #:_____ DRIVER'S LICENSE #: _____
REASON FOR TODAY'S VISIT? _____ TODAY'S DATE: _____

MAILING ADDRESS: Street_____ Apt. # _____
City _____ State _____ Zip _____ HOW LONG AT THIS ADDRESS:_____
HOME PHONE: _____
CELL PHONE: _____ FAX #: _____ EMAIL _____
EMPLOYER: _____ WORK PHONE: _____
OCCUPATION: _____ # OF YEARS EMPLOYED: _____
If Patient is a Minor, give Guardian's Name: _____ Relationship to Patient: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? HOW DID YOU HEAR ABOUT US?

_____
Do you speak a LANGUAGE other than English? _____YES _____NO If so, what language do you PREFER TO SPEAK?_____
PLEASE BRING A TRANSLATOR WITH YOU, SHOULD YOU REQUIRE ONE. THANK YOU.

RESPONSIBLE PARTY'S INFORMATION

☐ CHECK HERE IF THIS PATIENT IS ALSO THE RESPONSIBLE PARTY FOR THIS ACCOUNT. IF NOT, PLEASE COMPLETE BELOW.

NAME: Last _____ First _____ Middle _____ MARITAL STATUS: _____
RESIDENCE: Street _____ Apt. # _____ City _____ State _____ Zip _____
MAILING ADDRESS: Street _____ Apt. # _____ City _____ State _____ Zip _____
HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
FAX #: _____ EMAIL ADDRESS: _____
SOC. SEC. #: _____ BIRTH DATE: _____ DRIVER'S LICENSE #: _____ RELATION TO PATIENT: _____
EMPLOYER: _____ WORK PHONE: _____ OCCUPATION: _____ # OF YEARS EMPLOYED: _____

EMERGENCY INFORMATION: NEAREST RELATIVE NOT LIVING WITH YOU

NAME: Last _____ First _____ Middle _____
RESIDENCE: Street _____ Apt. # _____ City _____ State _____ Zip _____
PHONE NUMBER: _____ RELATION TO PATIENT: _____

DENTAL INSURANCE INFORMATION: PRIMARY CARRIER

INSURED'S NAME: _____ INSURANCE COMPANY: _____
INSURANCE CO. ADDRESS: _____ INSURED'S EMPLOYER: _____
INSURED'S SOCIAL SEC #: _____ GROUP #: _____ LOCAL #: _____
PLEASE INFORM OUR STAFF OF DUAL INSURANCE COVERAGE. We do not bill secondary insurance companies.

SPECIAL REQUESTS

PLEASE LIST ANY SPECIAL ACCOMMODATIONS NEEDED:_____

PATIENT Signature (GUARDIAN) _____ Date: _____

DENTAL & HEALTH HISTORY

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health.
This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY

	YES	NO
HOW LONG since your last dental visit?		
Last COMPLETE Dental Exam?		
Last CLEANING?		
Have you had any PERIODONTAL or GUM Treatments?	☐	☐
Are you having any PROBLEMS now?	☐	☐
WHAT are they?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your Dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you interested in Dental IMPLANTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
If so, WHY?		

	YES	NO
Do your gums BLEED, feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (Circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING of your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth? (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
ORAL HYGIENE: How often do you do the each of the flollowing?		
BRUSHING FLOSSING ORAL RINSES		
What kind of toothbrush do you use? (Please circle)		
Manual Rotary Sonic Other		
Do you use supplemental FLUORIDE?		
Do you have a Reverse Osmosis system? Do you drink bottled water?		

MEDICAL HISTORY

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
If so, what for?		
What MEDICATIONS are you currently taking?		
Are you taking any HERBAL or Over the Counter Medications?		

	YES	NO
Are you currently PREGNANT or are TRYING to get pregnant?	☐	☐
Are you taking any BIRTH CONTROL PILLS?	☐	☐
Do you use cigars/cigarettes, pipe or chewing TOBACCO?	☐	☐
If so, how much? For how long?		
Do you consume alcohol?	☐	☐
If so, how much? For how long?		
Do you or have you ever used any recreational drugs?	☐	☐
Is so, how much? For how long?		

CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease
Heart Attack
Angina Pectoris
High Blood Pressure
Low Blood Pressure
Heart Murmur
Rheumatic Fever
Congenital Heart Lesions
Mitral Valve Prolapse
Artificial Heart Valve
Heart Pacemaker
Artificial Joints (Hip, Knee)
Stroke or TIA

Kidney Disease
Ulcers
Gastric Reflux (GERD)
STD's (Syphilis, Gonorrhea, etc.)
AIDS / ARC / HIV Positive
Hepatitis A (Infectious)
Hepatitis B
Hepatitis C
Liver Disease
Anemia
Blood Transfusion
Hemophilia or Bleeding Disorders
Hypothyroidism
Hyperthyroidism

Bruise Easily
Type I Diabetes
Type II Diabetes
Arthritis
Pain in Jaw Joints
Corticosteroids
Frequent Headaches or Migraines
Epilepsy or Seizures
Fainting or Dizziness
Nervousness
Depression
Psychiatric Treatment
Chemotherapy (Cancer, Leukemia)
Radiation Treatment

Tuberculosis (TB)
Emphysema
Asthma
Bronchitis
COPD
Hay Fever
Seasonal Allergies or Hives
ADD
Developmental Disabilities
Physical Limitations
Alcoholism
Cosmetic Surgery
Glaucoma or Cataracts
Wear Glasses or Contact Lenses

ARE YOU ALLERGIC TO, OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING?

Aspirin Local Anesthetic Erythromycin Penicillin Codeine Nitrous Oxide Latex Other: _____

FAMILY PHYSICIAN: _____ PHONE NUMBER: _____

ADDRESS: Street _____ City _____ State _____ Zip _____

Last PHYSICAL EXAM date: _____ Weight in pounds: _____ (For purposes of calculating medication dosages)

BLOOD PRESSURE: _____ RAS / LAS PULSE: _____ BPM REGULAR / IRREG. TEMPERATURE: _____ Degrees Fahrenheit

PATIENT Signature: DATE: _____ DENTIST INITIALS: