# Patient Registration

Name (First, M.I., Last)_____Preferred Name _____

Birthdate_____Age_____Social Security #_____

Name of Spouse_____Birthdate_____Social Security #_____

Home Address _____ City _____ State_____ Zip_____

Home Phone _____ Cell Phone # _____ Email Address_____

Patient's Employer_____ Work Phone #_____

Spouse's Employer_____ Cell Phone # _____ Work Phone #_____

Full Time Student ☐ Yes Where?_____

Emergency Contact and Phone # _____

How did you hear about our office?_____

## Insurance Information

Dental Insurance? ☐ None ☐ One Insurance ☐ Two Insurances

Primary Insurance Name_____

Primary Insurance Address_____

Name of person in family who carries insurance_____

Who is covered? ☐ Self ☐ Spouse ☐ Family

Group Number_____ ID Number_____

Person Responsible for this Account (excluding insurance coverage) _____

Secondary Insurance Name_____

Secondary Insurance Address_____

Name of person in family who carries secondary insurance_____

Group Number_____ ID Number_____

## Dental History

Reason for visit?_____

Are you having any specific discomfort at this time? ☐ Yes ☐ No Describe:_____

How often do you have dental check-ups? ☐ every 3 months ☐ every 6 months ☐ other _____

Former Dentist's name_____ Last visit (month/year)_____

How often do you: Brush _____ Floss_____

How would you describe your feelings when you are at a Dental office? ☐ Nervous ☐ Indifferent ☐ Comfortable

Have you had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Bleeding gums | ☐ Yes | ☐ No | Jaw pain or tiredness | ☐ Yes | ☐ No |
| Blisters on lips or mouth | ☐ Yes | ☐ No | Lip or cheek biting | ☐ Yes | ☐ No |
| Broken teeth | ☐ Yes | ☐ No | Loose teeth | ☐ Yes | ☐ No |
| Burning sensation on tongue | ☐ Yes | ☐ No | Mouth breathing | ☐ Yes | ☐ No |
| Cigarette, pipe, cigar smoking | ☐ Yes | ☐ No | Orthodontic treatment | ☐ Yes | ☐ No |
| Clicking or popping jaw | ☐ Yes | ☐ No | Pain around ear | ☐ Yes | ☐ No |
| Do you clench your teeth? | ☐ Yes | ☐ No | Periodontal (gum) treatment | ☐ Yes | ☐ No |
| Dry mouth | ☐ Yes | ☐ No | Sensitivity to cold | ☐ Yes | ☐ No |
| Fingernail biting | ☐ Yes | ☐ No | Sensitivity to heat | ☐ Yes | ☐ No |
| Food collection between teeth | ☐ Yes | ☐ No | Sensitivity to sweets | ☐ Yes | ☐ No |
| Grinding teeth | ☐ Yes | ☐ No | Sensitivity to chewing | ☐ Yes | ☐ No |
| Gums swollen or tender | ☐ Yes | ☐ No | Sores or growths in mouth | ☐ Yes | ☐ No |

## Medical History

Are you allergic to any medications or substances (i.e. penicillin or latex)? Please list:

_____

Do you have or have you had any of the following conditions?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/ HIV | ☐ Yes | ☐ No | Diabetes Type II | ☐ Yes | ☐ No | Radiation Treatment | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No | Emphysema | ☐ Yes | ☐ No | Respiratory Disease | ☐ Yes | ☐ No |
| Anxiety | ☐ Yes | ☐ No | Epilepsy | ☐ Yes | ☐ No | Rheumatic Fever | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No | Fainting or Dizziness | ☐ Yes | ☐ No | Scarlet Fever | ☐ Yes | ☐ No |
| Artificial Heart Valves | ☐ Yes | ☐ No | Glaucoma | ☐ Yes | ☐ No | Shortness of Breath | ☐ Yes | ☐ No |
| Artificial Joints | ☐ Yes | ☐ No | Headaches | ☐ Yes | ☐ No | Sinus Problems | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | Heart Murmur | ☐ Yes | ☐ No | Skin Rash | ☐ Yes | ☐ No |
| Back Problems | ☐ Yes | ☐ No | Heart Problems | ☐ Yes | ☐ No | Special Diet | ☐ Yes | ☐ No |
| Bleeding abnormally with extractions or surgery | ☐ Yes | ☐ No | Hepatitis Type ___ | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| | | | Herpes Simplex Virus | ☐ Yes | ☐ No | Swollen Feet/ Ankles | ☐ Yes | ☐ No |
| Blood Disease | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No | Swollen Neck Glands | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Jaundice | ☐ Yes | ☐ No | Thyroid Problems | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No | Jaw Pain | ☐ Yes | ☐ No | Tumor Growth on Head or neck | ☐ Yes | ☐ No |
| Chemotherapy | ☐ Yes | ☐ No | Kidney Disease | ☐ Yes | ☐ No | | | |
| Circulatory Problems | ☐ Yes | ☐ No | Liver Disease | ☐ Yes | ☐ No | Ulcer | ☐ Yes | ☐ No |
| Congenital Heart Problems_____ | ☐ Yes | ☐ No | Low Blood Pressure | ☐ Yes | ☐ No | Venereal Disease | ☐ Yes | ☐ No |
| | | | Mitral Valve Prolapse | ☐ Yes | ☐ No | Unexplained Weight Loss | ☐ Yes | ☐ No |
| Cortisone Treatments | ☐ Yes | ☐ No | Osteoporosis | ☐ Yes | ☐ No | | | |
| Cough, persistent or Bloody | ☐ Yes | ☐ No | Pacemaker | ☐ Yes | ☐ No | Women: Are you currently pregnant? | | |
| Diabetes Type I | ☐ Yes | ☐ No | Psychiatric Care | ☐ Yes | ☐ No | ☐ Yes ☐ No | | |
| | | | | | | Due Date_____ | | |

## Medications

Please list any medications you are currently taking and the correlating diagnosis:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

I understand that the information I provide on this form is essential to determine my dental needs and the provision of dental treatment. I understand that if ANY change occurs in my health, I am to report it to the dentist at my next visit. I have read and understand each question, and have answered all of them truthfully and to the best of my ability. I have also discussed my health history with the doctor.

Patient Signature_____ Date_____
(parent or guardian, if patient is a minor)

I have reviewed the Patient Registration and Medical History form and have made any appropriate changes:

| Date | Initials | Date | Initials | Date | Initials | Date | Initials | Date | Initials | Date | Initials |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |
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