Patient Registration

Welcome to our Practice

Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental needs.

Name: (First) ________________ (MI) ___ (Last) ________________________ I prefer to be called: ________________

Date of Birth: (MM/DD/YYYY) _____________ Social Security #: ________________ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Student Status: ☐ Non-Student ☐ Part-Time ☐ Full-Time

Phone: Home ________________________ Work ________________________ Cell ________________________

Address: Street ____ City ________________ State ____ Zip ________

E-Mail Address: ____

What is your Preferred Contact Method? ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-Mail

What is your Preferred Contact Method for Confirmations? ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-Mail

What is your Preferred Contact Method for Recall? ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-Mail

How did you hear about us? (Whom may we thank for referring you?) ____

Insurance Information

Primary Insurance Subscriber Name: ____

Subscriber Birthdate: ______________________________ Subscriber ID #: ______________________________

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Insurance Company: ____ Phone: ________________________

Employer: ______________________________ Group Name: ________________ Group #: ________________

Secondary Insurance Subscriber Name: ____

Subscriber Birthdate: ______________________________ Subscriber ID #: ______________________________

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Insurance Company: ____ Phone: ________________________

Employer: ______________________________ Group Name: ________________ Group #: ________________

Authorization

I certify that I am covered by the Insurance Co. listed above and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Click to sign

Patient/Guardian Signature Date: 11/8/2018

Health History

Medical History Information

Patient Name: ______________________ (Last) (First) **Date of Birth:** ____________ (MM/DD/YYYY)

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ______________________ Physician's Phone: ____________

Date of last visit: ______________________

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ______________________

Do you use tobacco in any form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants placed? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No

Please list each one: ________ ________ ________ ________ ________

Are you allergic to any medications? ☐ Yes ☐ No

Please list each one: ______________________

Have you ever had any surgical procedures? ☐ Yes ☐ No

Please list each one: ______________________

Yes	No	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial Surgery
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Yes	No	Conditions
☐	☐	Glaucoma
☐	☐	HIV+ / AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sexually Transmitted Disease
☐	☐	Shingles

Yes	No	Conditions
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Yes	No	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Other *(list below)*:

Yes	No	If Female, Please Answer
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If so, # of Weeks ______
☐	☐	Are you nursing?

Emergency Contact:

Name: ______________________ Relationship: ____________

Address: ______________________

Phone: ______________________

Dental History Information

Date of last dental visit: ____________________ Name of your previous dentist: ___________________________________

Reason for today's visit? ____

Have you ever had an oral cancer screening? ☐ Yes ☐ No

How often do you floss your teeth? _______________________

Do your gums bleed when you brush? ☐ Yes ☐ No

Have you or a family member ever been treated for periodontal disease? ☐ Yes ☐ No

Have you ever bad complications from an extraction? ☐ Yes ☐ No

Have you ever bad a popping or clicking near your ear when you chew? ☐ Yes ☐ No

Are you prone to frequent headaches? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you have sores, blisters or swelling on your gums, lips or cheeks? ☐ Yes ☐ No

Have you ever had orthodontic treatment? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you have problems with bad breath? ☐ Yes ☐ No

Have you ever had an allergic reaction to a crown, metal filling or dental appliance? ☐ Yes ☐ No

Have you ever used an electric toothbrush? ☐ Yes ☐ No

Are your teeth sensitive to hot, cold or pressure? ☐ Yes ☐ No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you? _____

If you could change something about your smile what would it be?

- ☐ Whiter
- ☐ Straighter
- ☐ Close space
- ☐ Replace black mercury filling with tooth colored restorations
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Less gums showing
- ☐ Replace old crowns or caps that don't match

I certify that I have read and understand the questions above. I Acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Click to sign	Click to sign
Patient/Guardian Signature — **Date: 11/8/2018**	**Doctor Signature** — **Date: 11/8/2018**