

Patient Registration

Today's Date _____

Last Name _____ First Name _____ MI _____ Date of Birth _____ Age _____
Sex M or F Soc. Sec. # _____ Please Circle One: Single Married Separated Widow
Mailing Address _____ City _____ State _____ Zip Code _____
Email _____ Home Phone (____) _____ Cell Phone (____) _____
Driver's License # _____ Employer _____
Work Phone (____) _____ Occupation _____
Are you a full time student? Yes or No If patient is a minor: Mother's DOB _____ Father's DOB _____
Name of Parent _____ Parent Soc. Sec. # _____
Parent Employer _____ Parent Phone (____) _____
Person Responsible for Account _____ Relationship _____
Emergency Contact _____ Relationship _____ Phone # (____) _____

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name _____ Relationship _____

Reason for today's visit? _____

How did you hear about us?

In-home Mailer Social Media Insurance Practice Website Internet Family/Friend/Coworker

Other _____ Who can we thank for your visit? _____

Dental Insurance Information (Primary Carrier)

Dental Insurance Information Secondary Coverage

Insured's Name _____ Insured's Name _____

Insured's Employer _____ Insured's Employer _____

Insured's DOB _____ Insured's DOB _____

Insurance Co _____ Insurance Co _____

Insurance Co Address _____ Insurance Co Address _____

Insurance Phone # _____ Insurance Phone # _____

Group # _____ Local # _____ Group # _____ Local # _____

Dental History

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10

What would you like to change about your smile?

Color Bite Chipped Teeth Spaces Crowding Smile Makeover Missing Teeth Whiter Teeth

Please share the following dates:

Your last cleaning ____/____/____ Your last oral cancer screening ____/____/____ Your last complete X-rays ____/____/____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

Why did you leave your previous dentist? _____

Name of your previous dentist _____

Dental History Cont. - Please mark (x) any of the following conditions that apply to you

Patient Name (print) _____

Appearance

- Discolored teeth
- Worn teeth
- Misshaped teeth
- Crooked teeth
- Spaces
- Overbite
- Flat teeth

Pain/Discomfort

- Sensitivity (hot, cold, sweet)
- Pressure
- Broken teeth/fillings
- Worn teeth
- Dry Mouth

Function

- Grinding/Clenching
- Headaches
- Jaw Joint (TMJ) pain
- Jaw Joint (TMJ) clicking/popping
- Bad Bite
- Speech Impediment
- Mouth Breathing
- Sore Muscles (neck, shoulders)
- Difficulty Opening or Closing
- Difficulty Chewing on either side

Periodontal (Gum) Health

- Bleeding, Swollen, Irritated gums
- Bad breath
- Loose tipped, shifting teeth
- Previous perio/gum disease

Habits

- Thumb sucking
- Nail-biting
- Cheek/Lip biting
- Chewing on ice/foreign objects

Sleep Pattern or Conditions

- Sleep Apnea
- Snoring
- Daytime Drowsiness
- Bed wetting (for children)

Social

- Tobacco
How much _____ How long _____
- Alcohol Frequency _____
- Drugs Frequency _____

Previous Comfort Options

- Nitrous Oxide
- Oral Sedation (Pill)
- IV Sedation

Please list family history of any conditions marked:

Medical History - Please mark (x) to your response to indicate if you have or have had any of the following

Cancer

- Type _____
- Chemotherapy
- Radiation Therapy

Cardiovascular

- Angina (chest pain)
- Artificial Heart Valve
- Heart Conditions
- Heart Surgery
- High/Low Blood Pressure
- Mitral Valve Prolapse
- Pacemaker
- Rheumatic Fever
- Scarlet Fever
- Stroke

Endocrinology

- Diabetes
- Hepatitis A/B/C
- Jaundice
- Kidney Disease
- Liver Disease
- Thyroid Disease

Gastrointestinal

- Ulcers (Stomach)
 - Gastrointestinal Disease
- Hematologic/Lymphatic**
- Anemia
 - Blood Disorders
 - Bruise Easily
 - Excessive Bleeding

Musculoskeletal

- Arthritis
- Artificial Joints
- Jaw Joint Pain
- Rheumatoid Arthritis

Neurological

- Anxiety
- Depression
- Dizziness
- Drug/Alcohol Addiction
- Fainting
- Seizures
- Psychiatric Illness

Respiratory

- Asthma
- Emphysema
- Respiratory Problems
- Sinus Problems
- Sleep Apnea
- Tuberculosis

Viral Infections

- AIDS
- HIV Positive
- HPV

Women

- Currently Pregnant
- Nursing

Medical Allergies

- Antibiotics
(Penicillin/Amoxicillin /Clindamycin)
- Opioids
(Percocet, Oxycodone, Tylenol 3)
- Latex
- Local Anesthetics
- NSAIDs

Other Allergies

Additional Comments:

Are you under the care of a physician? Y or N If yes, please explain _____

Physician Name _____ Address: _____ Phone(_____) _____

Have you had a serious illness, operation, or hospitalization in the past 5 years? Y or N, If yes please explain _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Y or N If yes, please list all and why, including vitamins, natural or herbal supplements and/or dietary supplements _____

Have you ever in the past, or are you now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease? If so, please list medications: _____

Have you ever had surgery? If so, what type: _____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Signature of Patient/Legal guardian _____ Print Name _____ Date _____ Dentist Signature _____

For completion by dentist only | Additional Comments _____