PATIENT REGISTRATION

Please Print and Answer All Questions

PATIENT _____ Phone: Home _____ Work _____
Last Name First Name M.I.

Street Address _____

City _____ State _____ Zip Code _____

Email Address _____ Cell Phone _____

Birthdate _____/_____/_____ Social Security No. _____ ❑ Male ❑ Female ❑ Single ❑ Married

Driver's License Number _____ Employer _____

Spouse's Name _____ Spouse's Empl. _____ Work # _____

PERSON RESPONSIBLE FOR ACCOUNT ❑ Patient _____

DENTAL INSURANCE

Company _____

Group # _____

Phone # _____

Subscriber's SS# _____

Subscriber's Birthdate _____

IF YOU HAVE ADDITIONAL INSURANCE COVERAGE:

Company _____

Group # _____

Phone# _____

Subscriber's SS# _____

Subscriber's Birthdate _____

There are many medical situations which can affect or be affected by the procedures or drugs used for dentistry. Therefore, please fill out the following carefully. *Thank you.*

DATE OF LAST MEDICAL EXAM _____ Physician's Name _____ Phone _____

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING - INDICATE WITH ☒

- ❑ Allergies to drugs
- ❑ Allergies to anesthetics (Novocaine)
- ❑ Any heart ailments
- ❑ High blood pressure
- ❑ Neurological problems
- ❑ Radiation treatments
- ❑ Excessive bleeding from cut or extractions
- ❑ Anemia or blood problems
- ❑ Arthritis
- ❑ Fainting or dizzy spells
- ❑ Asthma
- ❑ Hayfever or allergies in general
- ❑ Diabetes
- ❑ Kidney problems
- ❑ Liver problems or hepatitis
- ❑ Malignancies
- ❑ Psychiatric care/emotional problems
- ❑ Rheumatic fever
- ❑ Sinus problems
- ❑ Epilepsy
- ❑ Stroke
- ❑ Thyroid
- ❑ Eye disorders
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer or colitis
- ❑ Venereal disease
- ❑ Prostate
- ❑ Pregnancy, If so, what month _____
- ❑ Hepatitis
- ❑ Herpes
- ❑ HIV Positive
- ❑ Emphysema
- ❑ Night sweats
- ❑ Prolonged fever
- ❑ Chronic diarrhea
- ❑ Chronic fatigue
- ❑ Sudden weight loss

Describe any current medical treatment, including drugs, impending operations, pregnancies or other information Doctor should be aware of:

_____

_____

_____

_____

Are you taking drugs for: ❑ High blood pressure ❑ Cortisone or steroids ❑ Blood thinners ❑ Sedatives or tranquilizers

Other: _____

_____

DATE OF LAST DENTAL EXAM _____ ANY PREVIOUS MAJOR DENTAL TREATMENT ❑ Yes ❑ No When? _____

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING - INDICATE WITH ☒

- ❑ Teeth sensitive to cold, heat, sweets or pressure
- ❑ Bleeding gums. How long?
- ❑ Food impaction
- ❑ Clenching or grinding
- ❑ Burning of tongue
- ❑ Swelling or lumps in mouth
- ❑ Frequent blisters on lips or mouth
- ❑ Pain around ear
- ❑ Unusual sounds in ear while eating
- ❑ Bad breath
- ❑ Unpleasant taste
- ❑ Unfavorable dental experience
- ❑ Complications from extractions
- ❑ Periodontal treatment
- ❑ Orthodontic treatment
- ❑ Mouth breathing
- ❑ Oral habits, i.e., fingernail biting, cheek biting, etc.
- ❑ Cigarettes, pipe or cigar smoking
- ❑ Texture of toothbrush _____
- ❑ Frequency of brushing _____
- ❑ Dental floss
- ❑ Inter dental stimulators
- ❑ Water jet stimulators
- ❑ Disclosing tablets or solution
- ❑ Fluoride supplements

I hereby certify that the above information is true and correct.

Signed: _____ Date _____