PATIENT REGISTRATION

Today's Date: _____

Patient's Name: Mr. Mrs. Miss _____ Male: ____ B-day _____ Home #_____

Female: ____ SSN _____ Work #_____

Patient Employed By _____

Patient Home Address _____ City_____ State _____ Zip _____

If child, mother's name: _____, Employed by _____ Work #_____

If child, father's name: _____, Employed by _____ Work #_____

Do you have insurance that may cover part of our professional services? o Yes or o No

Policy Holder's Name: _____ SSN _____ B-day_____

Employed by_____

Name of Primary Insurance Company _____

ID # _____ Group # _____

Company's Billing Address _____

Do you have Secondary Insurance Coverage? o Yes or o No

Policy Holder's Name: _____ SSN _____ B-day_____

Employed by_____

Name of Secondary Insurance Company_____

ID # _____ Group # _____

Company's Billing Address _____

H ! **Payment is expected when service is rendered unless other arrangements are made in advance.**

Who will pay this account? _____ SSN _____ B-day_____

Billing Address _____ Phone _____

Whom may we thank for referring you? _____

Signature _____

MEDICAL HISTORY (Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

DENTAL HEALTH

Reason for visit:		omment	
Date of last dental exam:		omment	
Date of last dental x-rays:		omment	
What are your main dental concerns?		omment	
Have you had problems with prior dental treatment?	○ Yes ○ No	If yes	
Do you wear dentures or partials? If yes, how long have you worn this pair? Is this your first pair?	○ Yes ○ No	If yes	
Have you had undesirable reactions from any of the following? Oral Surgery, Local Anesthetics, Tooth	○ Yes ○ No	If yes	
Have you ever taken antibiotic pre-medication prior to dental treatment? Why?	○ Yes ○ No	If yes	
Do your gums bleed when you brush?	○ Yes ○ No	If yes	
Have you had any periodontal (gum) treatments?	○ Yes ○ No	If yes	
How do you feel about the appearance of your	○ Yes ○ No	If yes	

GENERAL HEALTH

Are you under a physician's care now?	○ Yes ○ No	If yes	
Date of your last medical exam:		omment	
Have you ever been hospitalized or had a major	○ Yes ○ No	If yes	
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes	
Are you taking any medications, pills, drugs, herbal drugs, vitamins or OTC?	○ Yes ○ No	If yes	
Have you ever taken a bisphosphonate drug for osteoporosis or cancer (Fosamax, Boniva, Actonel)?	○ Yes ○ No	If yes	
Do you take, or have you taken, diet pills including Fen-Phen or Redux?	○ Yes ○ No	If yes	
Do you use tobacco (smoking, snuff, chew)? Amount/Frequency/Years of Use	○ Yes ○ No	If yes	
If yes to previous question, are you interested in stopping? Very/Somewhat/Not intersted	○ Yes ○ No	If yes	
Do you drink alcohol? Amount/Frequency/Years of	○ Yes ○ No	If yes	
Recreational drug use past or present?	○ Yes ○ No	If yes	
Do you have Asthma, Tuberculosis, Emphysema, other lung diseases?	○ Yes ○ No	If yes	
Eye disease or trouble?	○ Yes ○ No	If yes	
Skin disease or trouble, hives or rash?	○ Yes ○ No	If yes	
Hearing, Ear Trouble, Hearing Aids?	○ Yes ○ No	If yes	

CANCER/CARDIAC HEALTH

Do you have cancer? If yes, what type?	○ Yes ○ No	If yes	

Are you enduring, or have you undergone, any of the following?

Chemotherapy	○ Yes ○ No
Radiation Treatments	○ Yes ○ No

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

Heart Attack/Failure	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No
Congestive Heart Failure	○ Yes ○ No	Infective Endocarditis	○ Yes ○ No				

WOMEN ONLY

Women: Are you...

- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?
- ☐ Due Date:_____

PLEASE PROVIDE NAME OF PHYSICIANS/SPECIALISTS:

ALLERGIES

Are you allergic to any of the following?

Aspirin	Yes No	Penicillin	Yes No	Codeine	Yes No	Acrylic	Yes No
Metal	Yes No	Latex	Yes No	Sulfa Drugs	Yes No	Local Anesthetics	Yes No
Tylenol	Yes No	Other Narcotics	Yes No	NSAIDS	Yes No		

OTHER: Yes No If yes

CURRENT HEALTH

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

Abnormal Bleeding	Yes No	Cold Sore/Fever Blister	Yes No	Hearing Impairment	Yes No	Renal Dialysis	Yes No
AIDS/HIV Positive	Yes No	Cortisone/Steroid Medicine	Yes No	Hepatitis A	Yes No	Severe/Rapid Weight Loss	Yes No
Alzheimer's	Yes No	Diabetes Type I	Yes No	Hepatitis B or C	Yes No	Sexually Transmitted Disease	Yes No
Anaphylaxis	Yes No	Diabetes Type II	Yes No	High Cholesterol	Yes No	Shingles	Yes No
Anemia	Yes No	Drug Addiction	Yes No	Hypoglycemia	Yes No	Sinus Trouble/Allergies	Yes No
Angina/Chest Pains	Yes No	Dry Mouth	Yes No	Immunosuppression	Yes No	Stomach/Intestinal Disease/Ulcers	Yes No
Arthritis/Gout/Rheumatism	Yes No	Epilepsy or Seizures	Yes No	Kidney Problems	Yes No	Stroke	Yes No
Artificial Joint	Yes No	Excessive Bleeding	Yes No	Leukemia	Yes No	Systemic Lupus Erythematosus	Yes No
Blood Disease	Yes No	Fainting Spells/Dizziness	Yes No	Liver Disease	Yes No	Thyroid/Parathyroid Disease	Yes No
Blood Pressure - High	Yes No	Frequent Headaches	Yes No	Organ Transplant	Yes No	Tonsilitis	Yes No
Blood Pressure - Low	Yes No	Gastrointestinal Disease	Yes No	Osteoporosis	Yes No	Tumors or Growths	Yes No
Blood Transfusion	Yes No	Glaucoma	Yes No	Pain in Jaw	Yes No	Vision Impairment	Yes No
Chronic Pain	Yes No	.	Yes No	Psychiatric Care	Yes No		

Have you ever had any serious illness not listed Yes No If yes

COMMENTS:

Signature

Signature of Patient, Parent or Guardian:

X Date:_____