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)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Group # _____ Local # _____

Dental Insurance Information Secondary Coverage

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

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

_____

_____

_____