PATIENT REGISTRATION

Last Name	First Name	M.I.	Sex	Marital Status
Street Address	City, State, Zip		Home Phone	
Birthdate	Social Security Number	Driver License Number	Name of Responsible party	
Email	Cell Phone Number		Best way to contact you	
Employed by	Present Position	Do you have Dental Insurance?	If so, with who?	
Insurance Subscriber's Name	Subscriber's Social Security /Id#		Subscriber's Birthdate	
Ins. Group Number	Do you have additional Dental Insurance?	If so, with who?	Id#	Ins Group Number

MEDICAL HISTORY

Please Circle YES or NO

YES NO Do you consider your medical health to be good? _____When did you have your last medical check-up? _____

YES NO Are you taking ANY medications(prescription or non-prescription) regularly? Please list on back of sheet if necessary _____

YES NO Do you normally take antibiotics prior to dental treatment?

YES NO Are you being treated by a medical doctor at this time? _____ For what? _____

YES NO Have you recently gained or lost a significant amount of weight? _____

YES NO Have you ever had an injury to your face or jaws? _____

YES NO Do you smoke? _____ How much? _____Do you consume alcohol? _____ How much_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

YES NO	Heart Disease/Concerns (mitral valve prolapse,bypass surgery, pacemaker, Heart murmur, stent angioplasty, stroke)	YES NO	Cancer	YES NO	Arthritis
		YES NO	Radiation Treatment	YES NO	Sinus Trouble
		YES NO	Diabetes	YES NO	Hay Fever/Asthma
		YES NO	Lung Trouble - TB	YES NO	Psychiatric Treatment
YES NO	Rheumatic Fever	YES NO	Kidney Disease/Dialysis	YES NO	Venereal Disease
YES NO	Valve, Joint or Hip Replacement	YES NO	Liver Disease	YES NO	AIDS or HIV+(positive)
YES NO	High / Low Blood Pressure	YES NO	Epilepsy	YES NO	Herpes
YES NO	Bleeding Problems/ Blood Disease	YES NO	Ulcers	YES NO	Are you Pregnant?
YES NO	Infectious Hepatitis	YES NO	Glaucoma	YES NO	Alcohol / Drug abuse
YES NO	Organ Transplant	YES NO	Steriod use/ Therapy	YES NO	Thyroid Problems
YES NO	Stroke	YES NO	Multiple Sclerosis		

YES NO Have you ever had painful or swollen joints? YES NO Are you short or breath on mild exertion?

YES NO Do you use recreational drugs (cocaine, marijuana, etc)?

YES NO Does anyone in your family have a history of sugar diabetes?

YES NO Have you ever been hospitalized? WHY? _____WHEN?_____

YES NO Have you had any surgeries recently? _____

YES NO Are you allergic to or react to any medications or drugs (penicillin, aspirin, novacaine, etc.)?_____

PLEASE DESCRIBE ANY other Medical Treatment, impending operations or other medical or dental information that the doctor should know about _____

PATIENT REGISTRATION

FOR WOMEN

YES NO Are you pregnant, or do you think you may be pregnant? If so, due date: _____

YES NO Are you nursing?

YES NO Are you taking oral contraceptives?

DENTAL INFORMATION

What is the purpose of your visit today? _____

If this is your first visit to our office, when was your last checkup and cleaning?_____

YES NO Do you have any dental condition which you believe requires immediate attention today?

YES NO Have you ever had an unusual reaction to a local anesthetic? If so, what happened and when?

_____

YES NO Are you happy with your smile? If not, what would you like to change?_____

YES NO Have you ever had orthodontic treatment (braces) If so, when?_____

YES NO Have you ever had periodontal (gum) treatment? If so, when? _____

YES NO Do you wear a denture or partial?_____ Upper or Lower? _____

When was it made? _____ Is it comfortable? _____

YES NO Would it be OK with you to lose all your teeth and wear false teeth? _____

YES NO Have any of your teeth recently moved or separated and created spaces between them? _____

YES NO Does your jaw click when you chew? _____

YES NO Do you have pain in the region in front of your ears?

YES NO Do you tend to clench or grind your teeth? If so, when (daytime/nighttime)? _____

YES NO Have you ever been treated for TMJ syndrome? If so, when? _____

YES NO Do you have dark or unattractive fillings that you would like replaced?

YES NO DO you have missing teeth you would like replaced?

YES NO Are your gums red, swollen, receding, or do they bleed when brushing or flossing?

YES NO Is there any other information that was not asked, which you fell may influence your dental treatment? If so, What? _____

What is the name, address and phone number of your primary physician? _____

_____

I certify that the above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and / health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual dental bill for services rendered. I agree to be responsible for payment of all services rendered on my behalf or on my dependent's behalf.

_____ _____ _____

Patient / Guardian Signature Date Staff Initials