# REGISTRATION INFORMATION

Date: _____

Patient's Name _____
Last Name First Name Middle Initial Preferred Name

Patient's Social Security Number _____ Patient's Date of Birth _____ Patient's Age _____

Street Address _____

City _____ State _____ Zip code _____

Home Phone # _____ Business Phone # _____ Cell Phone# _____

Best Phone # to reach you? Home Work/Business Cell Phone (Please Circle )

Marital Status S_____ M_____ D_____ W____ Sex: M F (Please Circle)

Patient Employed By _____ Occupation _____

If full time student, name of college _____ City _____ State _____

**In Case of emergency, whom should we notify?** _____ **Phone #:** _____

**How did you learn of our Practice?** _____

## Responsible Party

Name of Person Responsible for this account _____ Relationship _____

Date of Birth _____ Social Security Number _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

## DENTAL INSURANCE – PRIMARY COVERAGE

Employee Name _____ Relationship to Patient _____

Employee Date of Birth _____ Employee Ins. ID # _____

Name of Employer _____ Employer Group # _____

Name of Insurance Co. _____ Telephone # _____

Insurance Address _____

## DENTAL INSURANCE – SECONDARY COVERAGE

Employee Name _____ Relationship to Patient _____

Employee Date of Birth _____ Employee Ins, ID # _____

Name of Employer _____ Employer Group # _____

Name of Insurance Co. _____ Telephone # _____

Insurance Address _____

## Patient Medical History

**Today's Date**_____

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now? _____
   Please explain _____
2. Have you been hospitalized for surgery or illness in the last 5 years? _____
   If yes, Please explain. _____
   _____
3. Please list any medication(s) including non-prescription medicine(s), (i.e. Aspirin, cold medications) you are currently taking. _____
   _____
4. Do you have any allergies? ____ If yes, please list.
   _____
5. Are you allergic to any antibiotics? (Penicillin, Sulfa ) _____
6. Do you have a Latex allergy? _____
7. Have you ever used Phen-Phen / Redux? _____
8. Do you use Tobacco? _____
9. Women Only:
   a. Are you pregnant? _____
   b. Are you nursing? _____
   c. Are you taking oral contraceptives? _____

10. **Do you have or have you had any of the following? (please check)**

| | | | | | |
|---|---|---|---|---|---|
| High Blood Pressure | _____ | Respiratory problems (Asthma, Emphysema) | _____ | Kidney Disease | _____ |
| Heart attack | _____ | Tuberculosis | _____ | Liver Disease | _____ |
| Heart Valve Replacement | _____ | Blood Related Disorders (Anemia, Leukemia) | _____ | Sexually Transmitted Disease | _____ |
| Heart Murmur | _____ | Cancer | _____ | HIV/AIDS | _____ |
| Rheumatic Fever | _____ | Chemotherapy | _____ | Hepatitis/ Jaundice | _____ |
| Cardiac Pacemaker | _____ | Radiation Therapy | _____ | Gastrointestinal Disorder | _____ |
| Chest Pains | _____ | Seizure Disorder | _____ | Colitis | _____ |
| Shortness of Breath | _____ | History of Fainting | _____ | Stomach Troubles/Ulcers | _____ |
| Low Blood Pressure | _____ | Psychiatric Disorder | _____ | Arthritis | _____ |
| Stroke | _____ | Diabetes | _____ | Bone Disease/Disorder | _____ |
| Joint Replacement or Implant | ____ | | | Vision Problems | _____ |
| If yes, when | _____ | | | Thyroid Problems | _____ |

11. **Have you ever been told that you have to be premedicated prior to dental appointments?** _____
12. **Do you take Fosamax or any Bisphosphonate derivative?** _____

## Patient Dental History

Name of previous Dentist and Location _____ Date of Last Exam _____

Please answer **YES** or **NO**.

1. Do your gums bleed while brushing or flossing? _____
2. Are your teeth sensitive to hot or cold liquids/foods? _____
3. Are your teeth sensitive to sweet or sour liquids/foods? _____
4. Do you feel any pain in your teeth? _____
5. Do you have any sores or lumps in or near your mouth? _____
6. Have you had any head, neck or jaw injuries? _____
7. Have you ever experienced any of the following problems in your jaw?
   Clicking _____
   Pain (joint, ear, side of face) _____
   Difficulty in opening, closing or chewing _____
10. Have you ever had any difficult extractions in the past? _____
11. Have you ever had any prolonged bleeding following extractions? _____
12. Have you had any orthodontic treatment? _____
13. Do you wear dentures or partials? *How old*? _____
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? _____
15. Do you like your smile? _____
16. Have you ever been diagnosed with periodontal (gum) disease? _____

**Authorization and release**

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

X_____ **Signature of Patient/Parent/Guardian**