Patient Registration Form

Email: Today's Date:

Preferred Name:[ ] Miss [ ] Mr. [ ]Mrs. [ ] Ms. [ ]Dr. Referred by:

Name: ( ) ( )

Last First Middle Home Phone Cell Phone

Address:

Mailing Address City State Zip

SS#: - - Date of Birth: / / Sex: [ ] M [ ] F

Employer: Business Phone:

Emergency Contact: Relationship: Home Phone: Cell Phone:

College Student Status: [ ] Full Time [ ]Part Time School Name:

Employment Status: Full Time Part Time Retired Address:

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed Address 2:

Pharmacy: Phone: ( ) City, State, Zip:

Dental Insurance Information

Primary Dental Insurance

Name of insured: Relationship to Patient: [ ]Self [ ] Spouse [ ] Child [ ] Other

Insured SS#: Insured Birthdate:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

ID#: Gr#:

Secondary Dental Insurance Information

Name of insured: Relationship to Patient: [ ]Self [ ] Spouse [ ] Child [ ] Other

Insured SS#: Insured Birthdate:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

ID#: Gr#:

Dental Information

Do your gums bleed when you brush or floss?	Y	N	Do you have earaches or neck pain?	Y	N
Are your teeth sensitive to hot, cold, sweets, or pressure?	Y	N	Do you have any clicking, popping or pain in your jaw?	Y	N
Is your mouth dry?	Y	N	Do you brux or grind your teeth?	Y	N
Have you ever had any periodontal treatment?	Y	N	Do you have sores or ulcers in your mouth?	Y	N
Have you ever had orthodontic treatment?	Y	N	Do you wear dentures or partials?	Y	N
Have you had problems associated with previous treatment?	Y	N	Do you participate in active recreational activities?	Y	N
Is your home water supply fluoridated?	Y	N	Have you ever had serious injury to head or mouth?	Y	N
Do you drink bottled or filtered water?	Y	N	Date of your last dental exam:	Y	N
If yes, how often? [ ] Daily [ ] Weekly [ ] Occasionally			What was done at that time?		
Are you currently experiencing dental pain or discomfort?	Y	N	Are you happy with your smile? [ ] Yes! [ ] No.		
What is the reason for your visit today?					

Signature:_____ Date:_____

Medical Information

Are you now under the care of a physician? [ ] Yes [ ] No

Physician Name:

Phone: Fax:

Address :

City: State: Zip:

Are you in good health? [ ] Yes [ ] No

Has there been any change in your general health in the past year?

If yes, what condition was treated?

Date of your last physical exam:

Do you wear contact lenses? [ ] Yes [ ]No

Are you taking, or have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine), or fen-phen (fenluramine-phentermine combination)? [ ] Yes [ ] No

Are you takeing or scheduled to begin taking either of the medications alendrontate (Fosamax) or risendronate (Actonel) for osteoporosis or Paget's disease? [ ] Yes [ ] No

Were you treated with or are you presently scheduled to begin treatment with the intravenous biophosphonates (Aredia or Zometa) for bonepain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastic cancer? [ ] Yes [ ] No
Date treatment began:

Have you has a serious illness, operation or been hospitalized in the last 5 years? [ ] Yes [ ] No
If yes what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)? [ ] Yes [ ] No

If yes, Please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Do you use controlled substances or drugs? [ ] Yes [ ] No

Do you use tobacco (Smoking, snuff, chew, bidis) [ ] Yes [ ] No
If so, how interested are you in stopping?
[ ] Very [ ] Somewhat [ ] Not Interested

Do you drink alcoholic beverages? [ ] Yes [ ] No

How much alcohol did you drink in the last 24 hours?

How much do you typically drink in a week?

Women Only Are you:
Pregnant? [ ] Yes [ ] No Number of weeks:
Nursing? [ ] Yes [ ] No
Taking birth control pills or hormone replacement? [ ] Yes [ ] No

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? [ ] Yes [ ]No Date:
If yes, list complications:

Allergies – Please check all that apply and specify reaction for each checked allergies.

[ ] Local anesthetic:
[ ] Aspirin:
[ ] Penicillin or other antibiotics:
[ ] Barbituates, sedatives, or sleeping pills:
[ ] Sulfa drugs:
[ ]Codeine or other narcotics:
[ ] Metals:
[ ] Latex (rubber):
[ ] Iodine:
[ ] Hay fever / seasonal:
[ ] Animals:
[ ] Food:
[ ] Other:

Heart murmur	[ ] Y [ ] N	Anemia	[ ] Y [ ] N	Chest pain upon exertion	[ ] Y [ ] N	Neurological disorders	[ ] Y [ ] N
Mitral valve prolapse	[ ] Y [ ] N	Blood transfusion	[ ] Y [ ] N	Chronic pain	[ ] Y [ ] N	If yes specify:	
Artificial heart valves	[ ] Y [ ] N	If yes, date:		Diabetes - Type I or II	[ ] Y [ ] N	Sleep disorder	[ ] Y [ ] N
Rheumatic fever	[ ] Y [ ] N	Hemophilia	[ ] Y [ ] N	Eating disorder	[ ] Y [ ] N	Mental health disorder	[ ] Y [ ] N
Cardiovascular disease	[ ] Y [ ] N	AIDS or HIV infection	[ ] Y [ ] N	Malnutrition	[ ] Y [ ] N	If yes, specify:	
Angina	[ ] Y [ ] N	Arthritis	[ ] Y [ ] N	Gastrointestinal disease	[ ] Y [ ] N	Recurrent infections	[ ] Y [ ] N
Arteriosclerosis	[ ] Y [ ] N	Autoimmune disease	[ ] Y [ ] N	G.E. Reflux / Persistent heartburn	[ ] Y [ ] N	Type of infection:	
Congestive heart failure	[ ] Y [ ] N	Rheumatoid Arthritis	[ ] Y [ ] N			Kidney problems	[ ] Y [ ] N
Coronary heart disease	[ ] Y [ ] N	Systemic lupus erythematosus	[ ] Y [ ] N	Ulcers	[ ] Y [ ] N	Night sweats	[ ] Y [ ] N
Damaged heart valves	[ ] Y [ ] N			Thyroid problems	[ ] Y [ ] N	Osteoporosis	[ ] Y [ ] N
Heart Attack	[ ] Y [ ] N	Asthma	[ ] Y [ ] N	Stroke	[ ] Y [ ] N	Persistent swollen glands in the neck	[ ] Y [ ] N
Low blood pressure	[ ] Y [ ] N	Bronchitis	[ ] Y [ ] N	Glaucoma	[ ] Y [ ] N		
High blood pressure	[ ] Y [ ] N	Emphysema	[ ] Y [ ] N	Hepatitis, jaundice, or Liver disease	[ ] Y [ ] N	Severe headaches / Migraines	[ ] Y [} N
Congenital heart defects	[ ] Y [ ] N	Sinus trouble	[ ] Y [ ] N				
Pacemaker	[ ] Y [ ] N	Tuberculosis	[ ] Y [ ] N	Epilepsy	[ ] Y [ ] N	STD's	[ ] Y [ ] N
Rheumatic heart disease	[ ] Y [ ] N	Cancer, chemotherapy, or Radiation treatment	[ ] Y [ ] N	Fainting spells or seizures	[ ] Y [ ] N	Sever or rapid weight loss	[ ] Y [ ] N
Abnormal bleeding	[ ] Y [ ] N					Excessive urination	[ ] Y [ ] N

Has any physician or dentist recommended that you take antibiotics prior to your dental treatment? [ ] Y [ ] N
Name of the physician or dentist making recommendation:

Do you have any disease, condition, or problem not listed above that you think your dentist should know about? [ ] Y [ ] N
Please explain:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff, responsible for any action that they take or do not take because of errors or omissions that I have made in completion of this form.

Date:_____ Signature of Patient / Legal Guardian:_____