

PATIENT REGISTRATION

Date _____

| PATIENT INFORMATION | | | | RESPONSIBLE PARTY/ GUARANTOR INFORMATION | | | | | |
|---------------------|-------------------------------|-------------------------------|-------------------------------|--|--------------------|-------------------------------|-------------------------------|-------------------------------|--------------------------------|
| Name | | | | Name | | | | | |
| Address | | | | Address | | | | | |
| City/State/Zip | | | | City/State/Zip | | | | | |
| Home# | | Cell# | | Home# | | Cell# | | | |
| Email | | | | Email | | | | | |
| Contact Preference | Home <input type="checkbox"/> | Work <input type="checkbox"/> | Cell <input type="checkbox"/> | Email <input type="checkbox"/> | Contact Preference | Home <input type="checkbox"/> | Work <input type="checkbox"/> | Cell <input type="checkbox"/> | Email <input type="checkbox"/> |
| Employer | | | | Employer | | | | | |
| Business Address | | | | Business Address | | | | | |
| City/State/Zip | | | | City/State/Zip | | | | | |
| Business Phone | | | | Business Phone | | | | | |
| Dental Insurance | | | | Dental Insurance | | | | | |
| Social Security # | | | | Social Security # | | | | | |
| Date of Birth | | | | Date of Birth | | | | | |

Driver's License # _____ Marital Status (Circle One) S M W D Minor Sex (circle one) M F

Referred by: _____

Name(s) of the other family members who are patients of this office? _____

HEALTH HISTORY

Physician's Name & Phone _____ Date of Last Physical Exam _____

Preferred Pharmacy & Phone _____

What Drugs, medication, or pills are you taking now? _____

Have you had an adverse or allergic reaction to: Penicillin _____ Novacaine _____ Other _____

Are you presently under the care of a physician? _____ If so, for what? _____

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

| YES | NO | | YES | NO | | YES | NO | |
|-------|-------|-----------------------------|-------|-------|--------------------------------|-------|-------|-------------------------------------|
| _____ | _____ | Glaucoma | _____ | _____ | Cortisone Therapy | _____ | _____ | Heart Murmur/Prosthetic Heart Valve |
| _____ | _____ | Shortness of Breath | _____ | _____ | Anticoagulant Therapy | _____ | _____ | Hepatitis or Liver Disease |
| _____ | _____ | Swollen Ankles | _____ | _____ | Diabetes | _____ | _____ | Heart Disease |
| _____ | _____ | Thyroid Disorder | _____ | _____ | Stroke | _____ | _____ | Psychiatric Treatment |
| _____ | _____ | Sinus Problems/Hayfever | _____ | _____ | Radiation Therapy/Chemotherapy | _____ | _____ | Chest Pain/Angina |
| _____ | _____ | Anemia | _____ | _____ | Convulsions/Epilepsy/Seizures | _____ | _____ | High/Low Blood Pressure |
| _____ | _____ | Bleeding or Blood Disorders | _____ | _____ | T.B. | _____ | _____ | Infectious Disease or AIDS |
| _____ | _____ | Emotional Disease | _____ | _____ | Rheumatic Fever | _____ | _____ | Joint Replacement |

Females YES NO

_____ Are you or do you suspect that you are pregnant?

_____ Taking Birth Control Pill/Oral Contraception?

_____ Taking Hormone Medication?

Are there any other medical conditions of which I should be made aware? _____

DENTAL HISTORY

At this moment do you have a toothache or any other pain in your head or neck? If so, please describe: _____

Date of last dental treatment or cleaning? _____ Date of last dental X-rays? _____ What type? _____

What do you like best about your teeth? _____

What do you like least about your teeth? _____

What would you like to change about your mouth or teeth if you could? _____

Do you have a history of:

| YES | NO | | YES | NO | |
|-------|-------|--------------------------|-------|-------|----------------------------|
| _____ | _____ | Gum Disease | _____ | _____ | Halitosis (Bad Breath) |
| _____ | _____ | Abscess | _____ | _____ | Sensitivities |
| _____ | _____ | Sores (Ulcers) | _____ | _____ | Pain in Jaw Joint |
| _____ | _____ | Grinding Teeth (BRUXISM) | _____ | _____ | TMJ |
| _____ | _____ | Clicking or Popping TMJ | _____ | _____ | Cold Sores/ Fever Blisters |

Are there any other dental conditions or experiences of which I should be made aware? _____

Signature (Patient, Parent, or Guardian)

Dentist's Signature