Patient Registration information

PLEASE PRINT

Patient Name: _____

First *MI* *Last*

Address: _____City:_____ ST____ Zip: _____

Phone: *(HM)* _____ *(WK)* _____ext.____ *(Cell)* _____

Email Address: _____**Date Of Birth**: _ _ /_ _ /_ _ _ _

Sex: M / F **Status:** ☐ Married ☐ Single ☐ Other _____

Whom may we thank for referring you to our practice? _____

Medical History

Health problems that you may have, or medications that you are taking, could have an affect on the dental treatment that you will receive. Thank you for answering the following questions.

●Primary care Physician _____Hospital _____ Phone# _____

●Do you need to take an antibiotic before having your teeth cleaned? **NO / YES** (**please explain**) Select _____

●Have you had:

☐ Subacute Bacterial Endocarditis , ☐ Artificial Heart Valve,

☐ Heart Transplant ☐ Congenital Heart Defect (excluding Mitral Valve Prolapse)

☐ Other Cardiac Conditions:_____

●Do you have any prosthetics or artificial joints? NO / YES (please explain) Select _____

●Do you have ☐Osteoporosis or ☐Osteopenia. ●Do you take any bone density medications (ie: Fosomax) _____

●Do you have any allergies to any of the following: ☐ **Local Anesthetics** ☐**Latex** ☐**Aspirin** ☐**Penicillin** ☐**Acrylic** ☐**Metal**

☐ **Other (please explain)**_____

●Have you ever had an Anaphylaxic reaction? NO / YES (please explain) Select _____

●Please list all medical conditions & medications you take for them. Use the reverse side if you need more space.

	Medications	**Reason for taking**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Please check all that apply

Blood Disorders
- ☐ Excessive Bleeding
- ☐ Hemophilia

Heart
- ☐ Heart Attack/Failure
- ☐ Chest Pains
- ☐ Angina
- ☐ Heart Pace Maker
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure

Infections DX
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Tuberculosis
- ☐ AIDS/HIV Positive

Cancer
- ☐ Type_____
  Date_____
  Treatment:
  _____

Liver Diseases
- ☐ Type_____
  Date_____
  Treatment:
  _____

Kidney Diseases
- ☐ Type_____
  Date_____
  Treatment:
  _____
- ☐ Renal Dialysis

Neurological
- ☐ Psychological Disorders
- ☐ Nervous Disorders
- ☐ Epilepsy or Seizures
- ☐ Stroke date: _____

Pulmonary
- ☐ Asthma
- ☐ Emphysema
- ☐ Frequent Cough
- ☐ Respiratory Problems

Pregnancy
- ☐ Pregnancy *Due date:* _____

Diabetic
- ☐ Insulin controlled
- ☐ Diet controlled

☐ ***Please list any <u>other</u> medical conditions that you think we should be aware of:***

_____

Dental History

●Please tell us what brought you to our office today. _____

●When was your last cleaning and exam? _____

●When was the last time you had x-rays _____●Would you be able to have x-rays forwarded to us? *NO / YES* Select

●Do you have now or have you had cavities or decay? *NO / YES* Select

●Have you had gum disease? *NO / YES* Select

1. Does your family have a history of gum disease? *NO / YES* Select
2. Do your gums bleed when you brush or floss? *NO / YES* Select

●Have you or do you have a history of TMJ or jaw pain? Please explain

_____

_____

●Do you experience any of the following:

- ☐ Sensitive teeth to hot/cold
- ☐ Sensitive teeth to pressure or biting
- ☐ Sensitive teeth to sweets
- ☐ Clenching or grinding teeth

●Do you frequently get cold sores or fever blisters? NO / YES Select

●Do you frequently get sores in your mouth? *NO / YES* Select

●Do you have dry mouth or take medications that make your mouth dry? *NO / YES* Select

●Have you or anyone in your family had oral cancer? *NO / YES* Select

●Do you or have you used tobacco products No / Yes. If Yes, how much weekly intake Select

●Do you consume alcoholic beverages No / Yes. If Yes how much weekly intake Select

●Have you ever had orthodontic treatment? NO / YES *(when)* Select _____

●Have you had your wisdom teeth removed? NO / YES *(when)* Select _____

●How would you rate your smile: 0

1 2 3 4 5 6 7 8 9 10

(Hate it) (Love it)

●Would you like to improve your smile? Yes No Select

●Is there anything in particular we can do to make you visit here comfortable?

_____

To The best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any change in medical status. Please sign in both spaces below.

X_____**Date:** _____

X_____**Date:** _____

I have read and understand this office's Notice of Privacy Practices (HIPAA).

Insurance Information

1.)Primary Dental Insurance

☐ ***Check if same as front page then skip to insurance company name.***
☐ ***Check if this person is responsible for the account.***

Name: _____ SS# _ _ _/_ _/_ _ _ _ Date of Birth: _ _/_ _/ _ _ _

Billing Address: _____

_____
City *State* *Zip*

Relation to: _____ Home #: _____ Other Phone#: _____

***Insurance Company**: _____
Address: _____
_____
City *State* *Zip*

*Phone:*_____ *Insured Id#* _____ *Group #* _____
Employer Name: _____ Work Phone#: _____

2.) Secondary Dental Insurance

☐ ***Check if same as front page then skip to insurance company name.***
☐ ***Check if this person is responsible for the account.***

Name: _____ SS# _ _ _/_ _/_ _ _ _ Date of Birth: _ _/_ _/ _ _ _
Billing Address: _____

_____
City *State* *Zip*

Relation to: _____ Home #: _____ Other Phone#: _____

***Insurance Company**: _____
Address: _____
_____
City *State* *Zip*

*Phone:*_____ *Insured Id#* _____ *Group #* _____
Employer Name: _____ Work Phone#: _____
