

WELCOME TO OUR OFFICE

Registration

Date _____

Patient's Name _____ Birthdate _____ Age _____ Soc.Sec.No. _____

Home Address _____ City/State _____ Zip _____ Phone _____

Person Financially Responsible _____ Relationship to You _____ Soc.Sec.No. _____

Occupation _____ Employer _____ City/State _____

Billing Address _____ City/State _____ Zip _____ Bus.Phone _____

Dental Insurance _____ Group/Plan No. _____ Referred By _____

Spouse Name _____ Employer _____ Soc.Sec.No. _____

Secondary Dental Insurance _____ Group/Plan No. _____ Ins.Co.Phone _____

Dental History

Why have you come to the dentist today? _____

When was your last checkup? _____

When was your last full mouth x-ray? _____

What did you like best about the last dental office you visited? _____

What did you like least? _____

Are you currently in pain? [] Yes [] No

Have you experienced any problem with any previous dental work [] Yes [] No

Do you have frequent headaches? [] Yes [] No

Do you now or have you ever had pain/discomfort in your jaw joint? [] Yes [] No

Your current dental health is [] Good [] Fair [] Poor

How often do you brush each day? [] 1 [] 2 [] 3 [] 4

Do you floss daily? [] Yes [] No [] Sometimes

Do your gums bleed? [] Yes [] No [] Sometimes

Have you ever had gum disease? [] Yes [] No

Do you have mobility in your teeth? [] Yes [] No

Does food sometimes get caught between your teeth? [] Yes [] No

Are your teeth sensitive to hot, cold, or anything else? [] Yes [] No

Have you lost any teeth? [] Yes [] No

If so, why? _____

Are you happy with the way your smile looks? [] Yes [] No

If not, what would you change? _____

Continued on Back

Medical History

Do you have a personal physician? Yes No

Physician's Name _____

Address _____

Phone No. _____ Date of last visit _____

Your current physical health is Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco products? Yes No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Latex	Y N Sulfa
Y N Codeine	Y N Penicillin	Y N Tetracycline
Y N Dental anesthetics	Y N Other antibiotics	Y N Other meds

Please list other medications that cause allergic reactions

Do you need premedication prior to dental work? Y N

For Women: Are you taking birth control pills? Y N

Are you pregnant? Unsure Yes No

week # _____

Are you nursing? Yes No

Are you taking any of the following?

Acetaminophen <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Pressure Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No	Recreational drugs <input type="checkbox"/> Yes <input type="checkbox"/> No
Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Remedies <input type="checkbox"/> Yes <input type="checkbox"/> No	Steroids/Cortisone <input type="checkbox"/> Yes <input type="checkbox"/> No
Antihistamines <input type="checkbox"/> Yes <input type="checkbox"/> No	Digitalis/Heart Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Medicine <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin/Diabetes Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	Tranquilizers <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Thinners <input type="checkbox"/> Yes <input type="checkbox"/> No	Nitroglycerin <input type="checkbox"/> Yes <input type="checkbox"/> No	

Are you taking any prescription/over the counter drugs not listed above? Yes No

If yes, please list each one: _____

Have you experienced the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Difficulty Breathing	Y N Herpes	Y N Severe Headaches
Y N Alcohol Abuse	Y N Drug Abuse	Y N High Blood Pressure	Y N Shingles
Y N Anemia	Y N Emphysema	Y N HIV+/ AIDS	Y N Sickle Cell
Y N Arthritis	Y N Epilepsy	Y N Hospitalized	Y N Sinus Problems
Y N Artificial Bones/Joints	Y N Fainting Spells	Y N Kidney Disorder	Y N Steroid Therapy
Y N Artificial Valves	Y N Fever Blisters	Y N Liver Disease	Y N Stroke
Y N Asthma	Y N Frequent Headaches	Y N Low Blood Pressure	Y N Thyroid Problems
Y N Blood Transfusion	Y N Glaucoma	Y N Mitral Valve Prolapse	Y N Tonsillitis
Y N Cancer	Y N Hay Fever	Y N Pacemaker	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Heart Attack	Y N Psychiatric Problems	Y N Ulcers
Y N Chicken Pox	Y N Heart Murmur	Y N Radiation Treatment	Y N Venereal Disease
Y N Colitis	Y N Heart Surgery	Y N Rheumatic Fever	
Y N Congenital Heart Defect	Y N Hemophilia	Y N Scarlet Fever	
Y N Diabetes	Y N Hepatitis	Y N Seizures	

If you answered Yes to any of the above, please explain: _____

I affirm that the information I have given today is correct to the best of my knowledge. I consent to whatever Dental Procedures and anesthetics are necessary for the treatment of the patient listed above.

Signature _____ Date _____

I agree to assume full Financial Responsibility for all treatment rendered. Signature _____ Date _____ I also agree to pay 1.5% interest on any balance over 30 days old.

Signature _____ Date _____