

PATIENT REGISTRATION

Thank you for choosing our office to assist you with your dental needs.
Please fill out the information below and don't forget to provide your signature at the end.

Patient's name _____ Date of birth _____

Sex _____ Social Security Number _____

If minor, name of legal guardian _____

Home phone _____ Mobile phone _____ Work phone _____

Mailing address _____ City _____ State _____ Zip _____

Email address _____ Employer _____

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

INSURANCE INFORMATION Not covered by dental insurance

Subscriber SS# _____ Member ID# _____ Group number _____

Dental Insurance Co. _____ Insurance phone # _____

Covered by spouse's insurance? Yes No Spouse's name _____

Spouse's dental insurance Co _____ Group number _____

Spouse's birthday _____ SS# or Member ID# _____

MEDICAL HEALTH HISTORY

Are you required to Pre-medicate before any Dental treatment?

**Do you have, or have you any of the following?
(Please check any that apply)**

- Blood disorders (Anemia)
- Blood transfusion
- Heart problems
- Heart murmur, mitral valve prolapse, heart defect
- Heart Pacemaker
- Stroke
- Bone or joint problems
- Artificial joint or valves placed
- High or low blood pressure (circle one)
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis, jaundice or other liver disease
- Diabetes TYPE 1 or TYPE 2
- Epilepsy or Neurological disorders
- Thyroid problems
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Cancer/Tumor
- Abnormal bleeding after any surgery (heavy bleeder)
- Hayfever or sinus trouble
- Allergies
- Asthma
- Stomach problems

Are you allergic to, or have reacted adversely to any of the following?

- Latex
- Penicillin or other antibiotics
- Local anesthetics
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Metals
- Other: _____

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners e.g. Coumadin)
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin other diabetes drugs
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Natural supplements
- Other: _____

Women:

- Are you pregnant or plan to become pregnant
- Taking hormones or contraceptives

Do you smoke, vape or use tobacco? Yes No

Primary medical physician: _____ Phone number _____

Patient's/Guardian signature _____ Date _____

Dentist signature _____ Date _____

welcome

Patient Number grid

PATIENT NUMBER

Patient's Name Last First Initial Date of Birth

- 1. Purpose of initial visit
2. Are you aware of a problem?
3. How long since your last dental visit?
4. What was done at that time?
5. Previous dentist's name
6. When was the last time your teeth were cleaned?

COMMENTS

- CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.
7. Have you made regular visits?
8. Were dental x-rays taken?
9. Have you lost any teeth or have any teeth been removed?
10. Have they been replaced?
11. How have they been replaced?
12. Are you unhappy with the replacement?
13. Would you like to know about permanent replacements?
14. Have you ever had any problems or complications with previous dental treatment?
15. Do you clench or grind your teeth?
16. Does your jaw click or pop?
17. Have you experienced any pain or soreness in the muscles or your face or around your ear?
18. Do you have frequent headaches, neckaches or shoulder aches?
19. Does food get caught in your teeth?
20. Are any of your teeth sensitive to:
21. Do your gums bleed or hurt?
22. Do you experience dry mouth?
23. How often do you brush your teeth?
24. Do you use dental floss?
25. Are any of your teeth loose, tipped, shifted or chipped?
26. Are you unhappy with the appearance of your teeth?
27. How do you feel about your teeth in general?
28. Do you feel your breath is offensive at times?
29. Have you ever had gum treatment or surgery?
30. Have you had any orthodontic work?
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?
32. Do you have any questions or concerns?

Large empty box for patient or dentist comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE
PATIENT'S / GUARDIAN'S SIGNATURE DATE
DENTIST'S SIGNATURE DATE

ANEST.

MED. ALERT

DENTAL HISTORY