REGISTRATION FORM / MEDICAL HISTORY

Your Dentist _____

PATIENT INFORMATION (CONFIDENTIAL) Date _____ Home Phone (_____)_____

Name _____ Birthdate _____ Soc. Sec. # _____ - _____ - _____

Address _____ City _____ State _____ ZIP _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employed By _____ Occupation _____ Work Phone (_____)_____

Business Address _____ City _____ State _____ ZIP _____

Spouse's Name_____ Spouse Employed by_____Bus. Phone (_____)_ _____

Person to Contact in Case of Emergency _____ Phone (_____)_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone (_____)_____

Driver's License # _____ Birthdate _____ Employer Work Phone _____

Is this person currently a patient of our office? ☐ Yes ☐ No

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Insurance Company _____

Group or Employer Name _____ Subscriber's Soc. Sec. # _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No

Name of Insured _____ Relationship to Patient _____

Insurance Company _____

Group or Employer Name _____ Subscriber's Soc. Sec. # _____

MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Visit _____

1. Are you under care or treatment now? ☐ Yes ☐ No
2. Have you ever been hospitalized for any surgical operation or serious illness? ☐ Yes ☐ No
3. Do you need to be premedicated for heart murmur (MVP) or joint replacement? ☐ Yes ☐ No
4. Are you taking any medication(s) including non-prescription medicine? ☐ Yes ☐ No
   If yes, what medication(s) are you taking? _____
5. Are you allergic to any medication(s)? ☐ Yes ☐ No
   If yes, what? _____
6. Are you wearing contact lenses? ☐ Yes ☐ No
7. Do you smoke? ☐ Yes ☐ No ☐ Cigarettes ☐ Pipe ☐ Cigars How many per day? _____ pack/day
8. Do you use alcohol, cocaine or other drugs? ☐ Yes ☐ No
9. Women Only
   a) Are you pregnant or think you may be pregnant? ..... ☐ Yes ☐ No
   b) Are you nursing? ..... ☐ Yes ☐ No
   c) Are you taking birth control pills? ..... ☐ Yes ☐ No

(over)

10. Do you have or have you had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Stomach Ulcers
☐	☐	Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Stroke
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur (MVP)	☐	☐	Hay Fever / Allergies
☐	☐	Thyroid Problem	☐	☐	Angina (Chest Pain)	☐	☐	Tuberculosis
☐	☐	Fainting	☐	☐	Frequently Tired	☐	☐	Radiation Therapy
☐	☐	Seizures	☐	☐	Anemia	☐	☐	Chemotherapy
☐	☐	Asthma	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Low Blood Pressure	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Epilepsy / Convulsions	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Leukemia	☐	☐	Joint Replacement	☐	☐	Psychiatric Treatment
☐	☐	Diabetes	☐	☐	Hepatitis / Jaundice	☐	☐	AIDS or HIV Infection
☐	☐	Kidney Disease	☐	☐	Sexually Transmitted Disease	☐	☐	Other

DENTAL HISTORY

1. Do your gums bleed while brushing or flossing? ☐ Yes ☐ No
2. Are your teeth sensitive to hot or cold liquids/foods? ☐ Yes ☐ No
3. Are your teeth sensitive to sweet or sour liquids/foods? ☐ Yes ☐ No
4. Do you feel pain to any of your teeth? ☐ Yes ☐ No
5. Do you clench or grind your teeth? ☐ Yes ☐ No
6. Have you ever had any prolonged bleeding following extractions? ☐ Yes ☐ No
7. Have you ever had periodontal treatment or gum treatment before? ☐ Yes ☐ No
8. How long have you been aware that you have a gum problem? _____
9. When were your teeth last cleaned? Date _____
10. How often do you brush your teeth? _____ per day
11. Which of the following do you use?

    Toothbrush: ☐ Soft ☐ Medium ☐ Hard ☐ Dental Floss ☐ Other _____
12. Are you satisfied or pleased with the way your teeth look? ☐ Yes ☐ No
13. Do you feel very nervous about having dental treatment? ☐ Yes ☐ No
14. How important is it for you to keep your own teeth? _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I understand that my dental insurance carrier may pay less than the dental bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent.

_____ _____

Signature of patient or parent if minor Date

COMMENTS: _____

_____

_____

_____

Signature of Doctor Date