PATIENT REGISTRATION
Please Print and Answer All Questions

PATIENT____________________________ Phone: Home__________ Work__________
Last First M.I.

Name of spouse______________________ If a child, parent's name______________

Address______________________ City__________ State__________ Zip__________

Birthdate ____/____/____ SS# __________ [ ] Sing. [ ] Mar. [ ] Sep. [ ] Div. [ ] Wid. Best time to call __________

Employer______________________ Present position______________ How long held__________

Employer Address______________________ City__________ State__________ Zip__________

Spouse's Employer______________________ Present Position______________ How long held__________

Employer Address______________________ City__________ State__________ Zip__________

Person responsible for account [ ] Patient [ ] Other ______________________

Is patient a full time student? [ ] Yes [ ] No If yes, where? ______________________

In case of emergency, who should be notified?______________________ Phone__________

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

Former dentist______________ Date of last visit?______________ What was done?______________

DENTAL INSURANCE	ADDITIONAL DENTAL INSURANCE
Insurance Carrier __________	Insurance Carrier __________
Employer __________	Employer __________
Subscriber's Name __________	Subscriber's Name __________
SS #__________ Gp #__________	SS #__________ Gp #__________

There are many medical situations which can affect or be affected by the procedures or drugs used for dentistry. Therefore, please fill out the following carefully. Thank you.

DATE OF LAST MEDICAL EXAM__________ Physician's Name______________________ Phone__________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING – INDICATE WITH (X)

__ Allergies to drugs
__ Allergies to anesthetics (Novacaine)
__ Any heart ailments
__ High blood pressure
__ Neurological problems
__ Radiation treatments
__ Excessive bleeding from cut or extractions
__ Anemia or blood problems
__ Arthritis
__ Fainting or dizzy spells
__ Asthma
__ Hayfever or allergies in general
__ Diabetes
__ Kidney problems
__ Liver problems or hepatitis
__ Malignancies
__ Psychiatric care/emotional problems
__ Rheumatic fever
__ Sinus problems
__ Epilepsy
__ Stroke
__ Thyroid
__ Eye disorders
__ Tonsillitis
__ Tuberculosis
__ Ulcer or colitis
__ Pregnancy,
If so, what month __________
__ Venereal disease
__ Prostate
__ Hepatitis
__ Herpes
__ HIV Positive
__ Emphysema
__ Night sweats
__ Artificial joints
__ Hip replacement

Describe any current medical treatment, including drugs, impending operations, pregnancies or other information Dr. should be aware of:

____
____
____

Are you taking drugs for: High blood pressure ______ Cortisone or steroids ______ Blood thinners ______ Sedatives or tranquilizers __________

Other______________________
____

DATE OF LAST DENTAL EXAM__________ ANY PREVIOUS MAJOR DENTAL TREATMENT [ ] Yes [ ] No When?__________

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING – INDICATE WITH (X)

__ Teeth sensitive to cold, heat, sweets or pressure
__ Bleeding gums. How long?__________
__ Food impaction
__ Clenching or grinding
__ Burning of tongue
__ Swelling or lumps in mouth
__ Frequent blisters on lips or mouth
__ Pain around ear
__ Unusual sounds in ear while eating
__ Bad breath
__ Unpleasant taste
__ Unfavorable dental experience
__ Complications from extractions
__ Periodontal treatment
__ Orthodontic treatment
__ Mouth breathing
__ Oral habits, i.e., fingernail biting, cheek biting, etc.
__ Cigarettes, pipe or cigar smoking
__ Texture of toothbrush __________
__ Frequency of brushing __________
__ Dental floss
__ Inter dental stimulators
__ Floss threaders
__ Proxabrush
__ Water jet device
__ Disclosing tablets or solution
__ Fluoride supplements

I hereby certify that the above information is true and correct.

Signed:______________________ Date:__________
Patient – Parent or Guardian (if under 18)