PATIENT REGISTRATION AND HISTORY

Patient Information

Please Present ID & Insurance Cards at the Front Desk. Thank You!

Today's Date_____

Patient Name_____
Last First Middle Initial

Preferred Name_____ SSN_____

Address_____

City_____ State_____ Zip_____

E-mail_____

Home Phone_____

Cell Phone_____

Birthdate_____ Age_____ Sex ☐ M ☐ F

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Patient Employer/School_____

Occupation_____

Employer/School Phone_____

Spouse's Name_____

Birthdate_____

Whom may we thank for referring you?_____

Minor/Child Consent

I, being the parent or guardian of

_____

Name of Minor/Child

do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date Signature of Insured/Guardian

Insurance Information

Who is responsible for this account?_____

Relation to Patient_____

Primary Insurance Co._____

Subscriber's Name_____

Birthdate_____ SSN_____

ID#_____ Group#_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Secondary Insurance Co._____

Subscriber's Name_____

Birthdate_____ SSN_____

ID#_____ Group#_____

In Case Of Emergency, Contact:

Name_____

Relation to patient_____

Phone_____

Preferred Contact Method

Dental Reminders…….

Sending reminders and important messages to your cell phone or email will allow us to contact you without interrupting your busy day with a phone call. There are still times we will call you, but our hope is these text messages and emails will make it easier to communicate with us! Please let us know the best way to contact you:

- ☐ Cell phone
- ☐ E-mail
- ☐ Home phone
- ☐ Any of the above!

Please give us a 24 hour notice if you need to cancel or reschedule your appointment to avoid a $50 missed appointment fee. Thank you!

PATIENT REGISTRATION AND HISTORY CONTINUED

HEALTH HISTORY

Physician's Name_____ Date of last visit_____

Have you ever had any of the following? Please circle Y for yes or N for no:

Y N AIDS/HIV	Y N Circulatory Problems	Y N Jaw Pain	Y N Sinus Trouble
Y N Arthritis	Y N Diabetes	Y N Kidney Disease	Y N Special Diet
Y N Artificial Heart Valves	Y N Epilepsy	Y N Liver Disease	Y N Stroke
Y N Artificial Joints	Y N Headaches	Y N Low Blood Pressure	Y N Swollen Neck Glands
Y N Back Problems	Y N Heart Problems	Y N Nervous Problems	Y N Thyroid Problems
Y N Blood Disease	Y N Hepatitis Type _____	Y N Psychiatric Care	Y N Ulcer
Y N Cancer	Y N High Blood Pressure	Y N Respiratory Disease	Y N Venereal Disease
Y N Chemical Dependency	Y N Jaundice	Y N Rheumatic Fever	Y N Weight Loss, unexplained

Have you ever used bisphosphonate medication? Brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ yes ☐ no

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combination of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ yes ☐ no

Is there anything else we should know about your medical history?_____

DENTAL HISTORY

Please circle yes or no to indicate if you have had any of the following:

Bad breath	yes	no	Lip or cheek biting	yes	no
Bleeding gums	yes	no	Loose or broken teeth	yes	no
Blisters in mouth	yes	no	Mouth breathing	yes	no
Clicking jaw	yes	no	Orthodontic treatment	yes	no
Clenching Teeth	yes	no	Pain around ear	yes	no
Dry mouth	yes	no	Periodontal treatment	yes	no
Grinding teeth	yes	no	Sensitivity to cold	yes	no
Gums sore	yes	no	Sensitivity to heat	yes	no
Jaw pain	yes	no	Sensitivity when biting	yes	no

Reason for today's visit _____

Former Dentist _____

Date of last dental visit_____

WOMEN

Do you suspect that you are pregnant? ☐ yes ☐ no

Are you nursing? ☐ yes ☐ no

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

Pharmacy_____ Phone _____

ALLERGIES

☐ Aspirin	☐ Local Anesthetic
☐ Barbiturates	☐ Penicillin
☐ Codeine	☐ Shellfish
☐ Iodine	☐ Sulfa
☐ Latex	☐ Other_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Date Signature