PATIENT REGISTRATION

Please present your Driver's License and Dental Insurance Card to the receptionist.

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

First Name:_____ **Last Name**:_____ **Middle Initial**:____

Preferred Name / Nickname:_____ **Sex**: ❑ Male ❑ Female

Date of Birth:___ ___ / ___ ___ / ___ ___ ___ ___ **Age**:___ ___ **Social Security #**:___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address:_____ **City**:_____ **State**: _____ **Zip** :_____

Home #: __ __ __ - __ __ __ - __ __ __ __ **Work #**: __ __ __ - __ __ __ - __ __ __ __ **Ext.**____ **Cell #**: __ __ __ - __ __ __ - __ __ __ __

Email address:_____ **Drivers License #**:_____ **Driver's License State**:_____

I would like to receive appointment reminders via (check all that apply): ❑ Mail ❑ Text ❑ Email

Responsible Party (if someone other than the patient)

First Name:_____ **Last Name**:_____ **Middle Initial**:___ **Sex**: ❑ Male ❑ Female

Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___ **Age**: ___ ___ **Social Security #**: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address:_____ **City**:_____ **State**: _____ **Zip** :_____

Home #: __ __ __ - __ __ __ - __ __ __ __ **Work #**: __ __ __ - __ __ __ - __ __ __ __ **Ext.** ____ **Cell #**: __ __ __ - __ __ __ - __ __ __ __

Email address:_____ **Drivers License #**:_____ **Driver's License State**:_____

PRIMARY INSURANCE INFORMATION

Name of Policy Holder: _____ **Relationship to Patient:** ❑ **Self** ❑ **Parent** ❑ **Spouse** ❑ **Other**

Policy Holder's Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **Policy Holder's DOB:** ___ ___ / ___ ___ / ___ ___ ___ ___

Member / Policy / Carrier ID: _____ **Employer ID / Group #:** _____

Employer Name:_____

Address:_____

Address 2:_____

City:_____ **State**:_____ **Zip**:_____

Occupation:_____

Employment Status: ❑ Full-Time ❑ Part-Time ❑ Retired

Insurance Company Name:_____

Address:_____

Address 2:_____

City:_____ **State**:_____ **Zip**:_____

Contact Number: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Annual Maximum:_____ **Annual Deductible**:_____

Remaining Benefits: _____

If you currently have Secondary Insurance Coverage, please complete the back of this form.

SECONDARY INSURANCE INFORMATION

Name of Policy Holder: _____ **Relationship to Patient: ❑ Self ❑ Parent ❑ Spouse ❑ Other**

Policy Holder's Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ __ **Policy Holder's DOB: ___ ___ / ___ ___ / ___ ___ ___ ___**

Member / Policy / Carrier ID: _____ **Employer ID / Group #: _____**

Employer Name:_____

Address:_____

Address 2:_____

City:_____ **State**:_____ **Zip**:_____

Occupation:_____

Employment Status: ❑ Full-Time ❑ Part-Time ❑ Retired

Insurance Company Name:_____

Address:_____

Address 2:_____

City:_____ **State**:_____ **Zip**:_____

Contact Number: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Annual Maximum:_____ **Annual Deductible**:_____

Remaining Benefits: _____

MEDICAL HISTORY

Patient Name _____ Birth Date __ __ / __ __ / __ __ __ __

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❑ Yes ❑ No If yes, please explain:_____

Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No If yes, please explain:_____

Have you ever had a serious head or neck injury? ❑ Yes ❑ No If yes, please explain:_____

Are you taking any medications, pills, or drugs? ❑ Yes ❑ No If yes, please explain:_____

Do you take, or have you taken, Phen-Fen or Redux? ❑ Yes ❑ No _____

Are you on a special diet? ❑ Yes ❑ No _____

Do you use tobacco? ❑ Yes ❑ No

Do you use controlled substances? ❑ Yes ❑ No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic
❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Other
If other, please explain:_____

Women: Are you…

❑ Pregnant / Trying to get pregnant?
❑ Nursing?
❑ Taking oral contraceptives?

Do you have, or have you had, any of the following?

❑ AIDS/HIV Positive
❑ Alzheimer's Disease
❑ Anaphylaxis
❑ Anemia
❑ Angina
❑ Arthritis / Gout
❑ Artificial Heart Valve
❑ Artificial Joint
❑ Asthma
❑ Blood Disease
❑ Blood Transfusion
❑ Breathing Problem
❑ Bruise Easily
❑ Cancer
❑ Chemotherapy
❑ Chest Pains
❑ Cold Sores / Fever Blisters
❑ Congenital Heart Disorder
❑ Convulsions
❑ Cortisone Medicine
❑ Diabetes
❑ Drug Addiction
❑ Easily Winded
❑ Emphysema
❑ Epilepsy or Seizures
❑ Excessive Bleeding
❑ Excessive Thirst
❑ Fainting Spells / Dizziness
❑ Frequent Cough
❑ Frequent Diarrhea
❑ Frequent Headaches
❑ Genital Herpes
❑ Glaucoma
❑ Hay Fever
❑ Heart Attack / Failure
❑ Heart Murmur
❑ Heart Pace Maker
❑ Heart Trouble / Disease
❑ Hemophilia
❑ Hepatitis A
❑ Hepatitis B or C
❑ Herpes
❑ High Blood Pressure
❑ Hives or Rash
❑ Hypoglycemia
❑ Irregular Heartbeat
❑ Kidney Problems
❑ Leukemia
❑ Liver Disease
❑ Low Blood Pressure
❑ Lung Disease
❑ Mitral Valve Prolapse
❑ Pain in Jaw Joints
❑ Parathyroid Disease
❑ Psychiatric Care
❑ Radiation Treatments
❑ Recent Weight Loss
❑ Renal Dialysis
❑ Rheumatic Fever
❑ Rheumatism
❑ Scarlet Fever
❑ Shingles
❑ Sickle Cell Disease
❑ Sinus Trouble
❑ Spina Bifida
❑ Stomach / Intestinal Disease
❑ Stroke
❑ Swelling of Limbs
❑ Thyroid Disease
❑ Tonsillitis
❑ Tuberculosis
❑ Tumors or Growths
❑ Ulcers
❑ Venereal Disease
❑ Yellow Jaundice

Have you ever had any serious illness not listed above? ❑ Yes ❑ No

If yes, please explain: _____

Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT / PARENT / GUARDIAN_____ DATE __ __ / __ __ / __ __ __ __

Welcome to our practice! This confidential information will help us prepare for your visit.

Name_____

Why have you made this dental appointment?

_____

Who may we thank for referring you to our office?

_____

Why did you leave the office of your previous dentist?

_____

Please check one box in each section.

- ❑ My mouth is very comfortable.
- ❑ My mouth is moderately comfortable.
- ❑ My mouth is uncomfortable.

- ❑ I think the appearance of my smile is excellent.
- ❑ I am satisfied with the appearance of my smile.
- ❑ I would like to change my smile.
- ❑ I am unconcerned about the appearance.

- ❑ I will do whatever I must to keep my teeth.
- ❑ I want to keep my teeth but only within a certain budget of time and money.
- ❑ I am indifferent about keeping my teeth.

- ❑ I have always done what was recommended to me.
- ❑ I have not done what was recommended to me.
- ❑ I have not had dentistry recommended to me.

- ❑ I put dental care for myself and family high on my list.
- ❑ I put dental care low on my list.
- ❑ I have never considered where I put dental care.

- ❑ I think my present state of dental health is excellent.
- ❑ I think my present state of dental health is good.
- ❑ I think my present state of dental health is poor.

Are you having any discomfort or pain? Y / N

How long has it been since your last dental visit? _____

What dental problems are you experiencing?

_____

Do you have any popping or clicking noises in your ears when you chew, open or move your mouth? Y / N

Have you ever experienced difficulty in achieving complete anesthesia? Y / N

If by magic you could change your smile or teeth, what changes would you like?

_____

Obstacles I see to having excellent dental care for myself…

If you select more than one of the following, please number them in order of significance with #1 being that which is most significant for you at this time.

_____ I see no obstacles
_____ Time away from work or other obligations
_____ Fear of pain, surgery, or injections
_____ Fear because of past dental experiences
_____ Cost of treatment
_____ Other _____