

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____

Last Name: _____

Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____

Last Name: _____

Middle Initial: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Birth Date: _____

Soc Sec: _____

☐ Responsible Party is also a Policy Holder for Patient☐ Primary Insurance Policy Holder☐ Secondary Insurance Policy Holder

Patient Information

Address: _____

Address 2: _____

City: _____

State / Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Sex: ☐ Male ☐ FemaleMarital Status: ☐ Married ☐ Single☐ Divorced☐ Separated☐ Widowed

Birth Date: _____

Age: _____

Soc Sec: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time☐ Part Time☐ RetiredStudent Status: ☐ Full Time☐ Part Time

Medicaid ID: _____

Pref. Dentist: _____

Employer ID: _____

Pref. Pharmacy: _____

Carrier ID: _____

Pref. Hyg: _____

Section 3

Whom Can We thank for telling you about us?

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

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Patient Name:

Birth Date:

Date Created:

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?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Date of last visit with physician?	<input type="text"/>		
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco? if Yes how much per day?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you use controlled substances?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>

Women: Are you...

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

Are you allergic to any of the following?

☐ Aspirin☐ Penicillin☐ Codeine☐ Acrylic☐ Metal☐ Latex☐ Sulfa Drugs☐ Local Anesthetics☐ Erythromycin

Other?

☐

If yes

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

AIDS/HIV Positive

☐ Yes ☐ No

Hemophilia

☐ Yes ☐ No

Radiation Treatments

☐ Yes ☐ No

Alzheimer's Disease

☐ Yes ☐ No

Diabetes type 1 or 2

☐ Yes ☐ No

Hepatitis A

☐ Yes ☐ No

Recent Weight Loss

☐ Yes ☐ No

Anaphylaxis

☐ Yes ☐ No

Drug Addiction

☐ Yes ☐ No

Hepatitis B or C

☐ Yes ☐ No

Renal Dialysis

☐ Yes ☐ No

Anemia

☐ Yes ☐ No

Herpes

☐ Yes ☐ No

Rheumatic Fever

☐ Yes ☐ No

Angina

☐ Yes ☐ No

Emphysema

☐ Yes ☐ No

High Blood Pressure

☐ Yes ☐ No

Rheumatism

☐ Yes ☐ No

Arthritis/Gout

☐ Yes ☐ No

Epilepsy or Seizures

☐ Yes ☐ No

High Cholesterol

☐ Yes ☐ No

Artificial Heart Valve

☐ Yes ☐ No

Excessive Bleeding

☐ Yes ☐ No

Hives or Rash

☐ Yes ☐ No

Shingles

☐ Yes ☐ No

Artificial Joint

☐ Yes ☐ No

Excessive Thirst

☐ Yes ☐ No

Hypoglycemia

☐ Yes ☐ No

Asthma

☐ Yes ☐ No

Fainting Spells/Dizziness

☐ Yes ☐ No

Irregular Heartbeat

☐ Yes ☐ No

Sinus Trouble

☐ Yes ☐ No

Blood Disease

☐ Yes ☐ No

Frequent Cough

☐ Yes ☐ No

Leukemia

☐ Yes ☐ No

Stomach/Intestinal Disease

☐ Yes ☐ No

Breathing Problems

☐ Yes ☐ No

Frequent Headaches

☐ Yes ☐ No

Liver Disease

☐ Yes ☐ No

Stroke

☐ Yes ☐ No

Bruise Easily

☐ Yes ☐ No

Low Blood Pressure

☐ Yes ☐ No

Swelling of Limbs

☐ Yes ☐ No

Cancer

☐ Yes ☐ No

Glaucoma

☐ Yes ☐ No

Lung Disease

☐ Yes ☐ No

Thyroid Disease

☐ Yes ☐ No

Chemotherapy

☐ Yes ☐ No

Hay Fever

☐ Yes ☐ No

Mitral Valve Prolapse

☐ Yes ☐ No

Tonsillitis

☐ Yes ☐ No

Chest Pains

☐ Yes ☐ No

Heart Attack/Failure

☐ Yes ☐ No

Osteoporosis

☐ Yes ☐ No

Tuberculosis

☐ Yes ☐ No

Cold Sores/Fever Blisters

☐ Yes ☐ No

Heart Murmur

☐ Yes ☐ No

Pain in Jaw Joints

☐ Yes ☐ No

Tumors or Growths

☐ Yes ☐ No

Congenital Heart Disorder

☐ Yes ☐ No

Heart Pacemaker

☐ Yes ☐ No

Ulcers

☐ Yes ☐ No

Convulsions

☐ Yes ☐ No

Heart Trouble/Disease

☐ Yes ☐ No

Psychiatric Care

☐ Yes ☐ No

Clenching/Grinding teeth

☐ Yes ☐ No

Have you ever had any serious illness not listed above?

☐ Yes ☐ No

If yes

Do you require a Pre-med prior to dental treatment?

☐ Yes ☐ No

Current oral concerns?

☐ Yes ☐ No

If yes

How often do you brush/floss your teeth?

Date of last dental visit? (Type N/A if currently established in this office)

Name of previous dental provider? (Type N/A if currently established in this office)

Do your gums bleed?

☐ Yes ☐ No

Are you interested in whitening?

☐ Yes ☐ No

Do you snore?

☐ Yes ☐ No

Which of these do you own?

Retainer(s)

☐ Yes ☐ No

Night Guard

☐ Yes ☐ No

C-Pap

☐ Yes ☐ No

How often do you wear?

☐ Sometimes

☐ Always

☐ Never

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 or Guardian:

X

Date: _____