

PATIENT REGISTRATION FORM

Patient Name _____ Date _____

Address _____ City, State, Zip _____

Home# _____ Work# _____ Cell# _____ Email _____

Sex M ___ F ___ Age ___ Birthdate _____ Marital Status _____

Employed By _____ Patient SS# _____

Who is Responsible for Account? _____ Phone _____

Name of Person Insured _____ SS# _____

Person Insured Employed By _____ Phone _____

Dental Insurance Carrier _____ Group# _____

Insurance Address _____ Phone _____

Spouse Name _____ Work Phone _____

Physician's Name _____ Phone _____

Date of Last Medical Exam _____

DO YOU OR HAVE YOU EVER HAD

	Yes	No		Yes	No
Heart Problems	___	___	AIDS (HIV)	___	___
High Blood Pressure	___	___	Rheumatic Fever	___	___
Stroke	___	___	Hepatitis	___	___
Artificial Valves, Joints	___	___	Ulcer	___	___
Respiratory Problems	___	___	Abnormal Bleeding	___	___
Diabetes	___	___	Mental Disorders	___	___
Epilepsy	___	___	Cancer	___	___
Allergies to Medicines	___	___	Radiation Treatment	___	___

Yes No

Are you under the care of a physician? Why? _____

	Yes	No
Have you ever received a blood transfusion?	___	___
Are you taking any medications? List _____	___	___
Are you allergic to any medications? List _____	___	___
Have you ever had a reaction to dental anesthetic?	___	___
Do you need pre-medication for dental treatment?	___	___
Do you suspect you are pregnant?	___	___
Anything more we should know about your medical history?	___	___

Primary reason for dental appointment: ___ Exam ___ Emergency ___ Consultation

When was your last visit to the dentist? And what services were performed? _____

	Yes	No
Do you have a specific dental problem?	___	___
Do you visit the dentist on a routine basis?	___	___
Have you had dental x-rays in the past year?	___	___
Would you describe your dental health as good?	___	___
Do you brush and floss on a routine basis?	___	___
Do you think you have active decay, or gum disease?	___	___
Have you noticed any loosening of your teeth?	___	___
Do you suffer from pain and/or swelling of your gums?	___	___
Do your gums often bleed when you brush your teeth?	___	___
Have you ever been treated for gum disease?	___	___
Are you missing any teeth?	___	___
Have missing teeth been replaced?	___	___
If not, have replacements been discussed?	___	___
Do you ever have clicking, popping, or discomfort in your jaw?	___	___
Do you ever grind your teeth?	___	___

	Yes	No
Have you ever worn braces?	___	___
Have you ever suffered a traumatic injury to your teeth?	___	___
Do you like the color of your teeth?	___	___
Do you like the shape of your teeth and smile?	___	___
If you could, would you change anything about your smile?	___	___
Do you snore?	___	___
If there was a simple way to treat this, would you be interested?	___	___
Do you feel nervous about having dental treatment?	___	___
Have you ever had an upsetting experience in a dental office?	___	___
Is there anything else about having dental treatment that bothers you?	___	___

Whom May we thank for referring you? _____

Payment is expected at the time of service unless previous arrangements have been made.

The information on this form is accurate and complete to the best of my knowledge.

Date _____ Signature of Patient or Guardian _____

Please complete and print form to bring with you to your initial appointment. If you have scheduled your appointment a week in advance, please mail us the form to save time.