Patient Registration

Patient's 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 Code: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____ Ext: _____

Birthdate: _____ Soc. Sec: _____ Driver's License: _____

☐ 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 Code: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____ Ext: _____

Sex: ☐ Male ☐ Female ☐ Pref. not to say Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birthdate: _____ Age: _____ Soc. Sec: _____ Driver's License: _____

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

Employment status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hygiene: _____

Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Security: _____ Insured birthdate: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Remaining Benefits: _____ Remaining Deductible: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Security: _____ Insured birthdate: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Remaining Benefits: _____ Remaining Deductible: _____

Medical History Form

Name: _____ Birthdate: _____ 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?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Are you required to take antibiotics prior to dental treatment for heart condition or artificial joint?	◯ Yes ◯ No	If yes	
Have you been diagnosed with sleep apnea? If yes, do you use a CPAP or similar device?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Do you use tobacco?	◯ Yes ◯ No	If yes	
Do you use controlled substances?	◯ Yes ◯ No	If yes	

Are you Allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Latex ☐ Penicillin ☐ Sulfa Drugs ☐ Other Antibiotics ☐ Local Anesthetics ☐ Nitrous Oxide ☐ Other Allergy ☐ Acrylic ☐ Metal

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 ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addition ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ 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	Scarlet Fever ◯ 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/Dry Mouth ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heart Beat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ 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	Frequent Vomiting ◯ 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 Growth ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes _____

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: _____

Dental History Form

Name: _____ Nickname: _____ Age: _____

Referred by: _____

How would you rate the condition of your mouth? ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Previous Dentist: _____

How long were you a patient? _____ **Years** _____ **Months**

How long since: Last dental exam: _____ Last cleaning: _____ Last dental treatment: _____

I routinely see my dentist every: ☐ **3mo.** ☐ **4mo.** ☐ **6mo.** ☐ **12mo.** ☐ **Not routinely**

What is your immediate concern? _____

Please Answer the Following:

Personal History

Are you fearful of dental treatment? ☐ **YES** ☐ **NO**

How fearful on a scale of 1 (least) to 10 (most)

☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

Have you ever had complications from past dental treatment? ☐ **YES** ☐ **NO**

Have you ever had trouble getting numb or had any reactions to local anesthetics? ☐ **YES** ☐ **NO**

Did you ever have braces, orthodontic treatment, or had your bite adjusted? ☐ **YES** ☐ **NO**

Have you had any teeth removed? ☐ **YES** ☐ **NO**

Smile Characteristics

Is there anything about the appearance of your teeth that you would like to change? ☐ **YES** ☐ **NO**

Have you ever whitened (beached) your teeth? ☐ **YES** ☐ **NO**

Have you felt uncomfortable or self-conscious about the appearance of your teeth? ☐ **YES** ☐ **NO**

Have you been disappointment with the appearance of previous dental work? ☐ **YES** ☐ **NO**

Bite and Jaw Joint

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ☐ **YES** ☐ **NO**

Do you /would you have any problems chewing gum? ☐ **YES** ☐ **NO**

Have your teeth changes in the last 5 years, become shorter, thinner, or worn? ☐ **YES** ☐ **NO**

Are your teeth crowding or developing spaces? ☐ **YES** ☐ **NO**

Do you have more than one bite, or have to squeeze to make your teeth fit together? ☐ **YES** ☐ **NO**

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ☐ **YES** ☐ **NO**

Do you clench your teeth in the daytime or at night? ☐ **YES** ☐ **NO**

Do you have any problems with sleep or wake up with an awareness of your mouth? ☐ **YES** ☐ **NO**

Do you wear or have you ever worn a bite appliance? ☐ **YES** ☐ **NO**

Tooth Structure

Have you had any cavities within the past 5 years? ☐ **YES** ☐ **NO**

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ☐ **YES** ☐ **NO**

Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ☐ **YES** ☐ **NO**

Are any teeth sensitive to hot, cold, biting, or sweets? ☐ **YES** ☐ **NO**

Do you avoid brushing any part of your mouth? ☐ **YES** ☐ **NO**

Do you have grooves or notches on your teeth near the gumline? ☐ **YES** ☐ **NO**

Have you ever broken teeth, chipped teeth, or had a cracked filling, or toothache? ☐ **YES** ☐ **NO**

Do you frequently get food caught between any teeth? ☐ **YES** ☐ **NO**

Gum and Bone

Do your gums bleed or are they painful when brushing or flossing? ☐ **YES** ☐ **NO**

Have you ever been treated for gum disease or been told you have lost bone around your teeth? ☐ **YES** ☐ **NO**

Have you ever noticed an unpleasant taste or odor in your mouth? ☐ **YES** ☐ **NO**

Is there anyone with a history of periodontal disease in your family? ☐ **YES** ☐ **NO**

Have you ever experienced gum recession? ☐ **YES** ☐ **NO**

Have you ever had any teeth become loose on their own (without an injury)? ☐ **YES** ☐ **NO**

Have you ever experienced a burning sensation in your mouth? ☐ **YES** ☐ **NO**

Patient's Signature Date