PATIENT REGISTRATION

DATE________________________

ACCOUNT________________-_______

Patient's Name____/______________________ Sex M F

Last First Middle Initial Preferred Name/ Nickname

Title: Mr. Mrs. Ms. Dr. Marital Status : Single Married Divorced Widowed Separated Birthdate_______/______/________

Patient's Address ________________________________City____________ State________ Zip________ Cell________________________

Home Phone________________________ Patients SS #_________-______-________ Email___________________@___________________

Patients Employer ____________________________ Phone________________________ Patients Occupation________________________

Name of Spouse__________________________________ Spouse SS # _________-________-_________ Birthdate_______/______/________

Last (if Different) First

Spouse's Employer____________________________ Phone ________________________ Occupation ______________________________

Who is responsible for this account? Self Spouse Mother Father Other ______________________ Phone __________________________

Person to Contact in Emergency_______________________________Phone_______________________Relationship___________________

REFERRED TO OFFICE BY____ Drive by / TV commercial / internet / Facebook / walk in

FOR PATIENTS COVERED BY INSURANCE

Date Eligible_______________

Subscriber's Name__________________________________ Birthday_______/_______/_______ SS # __________-_______-__________

Subscriber's Employer____________________________ Dental Insurance _________________________Phone________________________

Group #_______________Employee/Alt ID No._________________________ Patient's relationship to Subscriber Self Spouse Dependent

SECONDARY INSURANCE INFORMATION

Date Eligible_______________

Subscriber's Name _________________________________ Birthday_______/_______/________ SS# __________-_________-__________

Subscriber's Employer___________________________ Dental Insurance_________________________Phone________________________

Group #________________ Employee/Alt ID No. _______________________Patient's relationship to Subscriber Self Spouse Dependent

Dental Information:

Do your gums bleed when you brush or floss Y N

Have you had periodontal (gum) treatments or Surgery Y N

Are your teeth sensitive to cold, hot, sweets, or pressure Y N

Have you ever had orthodontic (braces) Y N

Do you have clicking, popping, discomfort in the jaw Y N

Do you snore or have sleep apnea Y N

If yes, do you wear a sleep appliance Y N

Do you have dry mouth problems Y N

Surgery/perio treatment Date _______________

Have you had a serious injury to your head or mouth Y N

Do you have any problems or allergies with anesthetic Y N

Do you brux (grind) or clench your teeth Y N

Do you wear dentures or partials Y N

What year were they made ___________________________

Name of previous dentist/last visit _________________________________Date______________ Phone: ______________________

How do you feel about your smile? Would you like to change anything about the appearance of your teeth (whitening, braces, fill in missing spaces) ________________________________

Do you have any anxiety about dental treatment? Explain:________________________________

Medical Information:

1. **Has your physician ever advised you to take antibiotics prior to dental treatment Y N**
   Have you had a total joint replacement or any organ transplants Date_____________ Y N
   Do you have a prosthetic (artificial) heart valve Y N
   Do you have congenital heart disease (from birth) Y N
2. **Are you currently or have you ever taken any oral or IV medications (bisphosphonates) for osteoporosis or bone related cancer Y N**
   If yes, when was your last treatment _____________________ Oral or IV ________________
3. **List any and all medications, vitamins or herbs you are currently taking:**________________________________

________________________________ ☐ **SEE LIST IN CHART**

Do you take aspirin or blood thinning medications (Plavix, Coumadin, Warfarin…) Y N

Has there been any change in your health in the past year: Y N If yes, explain: ____________________

Please list any prior surgeries you have had and the year: ________________________________

Date of last physical: _______________**Physician Name:** ____________________ **Phone Number:** ____________________

Do you smoke/chew tobacco Y N how many packs a day ___________

Do you have any history of addiction to alcohol or drugs Y N Do you drink alcohol Daily Weekly Monthly

4. **(Women) Are you taking birth control pills or undergoing hormone replacement therapy Y N**
   If trying to get pregnant or pregnant, how many weeks __________ **Nursing Y N**

5. **Allergies: Are you allergic to or have you had a reaction to any of the following:**

Latex Allergy	**Y N**	**Aspirin**	**Y N**	**Penicillin**	**Y N**	**Iodine**	**Y N**
Codeine or other narcotics	**Y N**	**Metals**	**Y N**	**Sulfa**	**Y N**	**Sedatives**	**Y N**

Other antibiotics/drugs ________________________________

Cardiovascular (Heart) Disease.....Y N	**Angina..........................Y N**	**Heart Attack Date __________Y N**	**Stroke Date____________ Y N**
Congestive Heart Failure.............Y N	**Damaged Heart Valves .Y N**	**Heart Murmur.......................Y N**	**High/Low Blood Pressure....Y N**
Mitral Valve Prolapse..................Y N	**Pacemaker..................Y N**	**Rheumatic Fever................... Y N**	**Anemia or Blood Disorder...Y N**
Abnormal Bleeding.....................Y N	**Blood Transfusion........ Y N**	**Autoimmune Disease.............Y N**	**Cancer Year__________ Y N**
AIDS/HIV....................................Y N	**Asthma.......................Y N**	**Hepatitis or Liver Disease........Y N**	**Radiation/Chemo..............Y N**
Emphysema................................Y N	**Arthritis.......................Y N**	**Sinus Trouble /Hay Fever........Y N**	**Tuberculosis.......................Y N**
COPD..Y N	**Headaches/Migraines....Y N**	**Ulcers...................................Y N**	**Thyroid Problems..............Y N**
Osteoporosis..............................Y N	**Hypoglycemia...............Y N**	**Diabetes...............................Y N**	**Eating Disorder..................Y N**
Glaucoma..................................Y N	**Epilepsy or Seizures.......Y N**	**Neurological Disorders...........Y N**	**Recurrent Infections...........Y N**
Physical,Mental or Emotional.......Y N	**Psychiatric Care............Y N**	**Kidney Problems....................Y N**	**Herpetic or HPV Infections..Y N**
Disability or Disorder	**Serious Accident...........Y N**	**Reflux....................................Y N**	**Gastrointestinal Disease.....Y N**
Severe or Rapid weight loss.........Y N			

Do you have any diseases or conditions not mentioned above that we should know about? Y N

Explain: ________________________________

Signature of Dentist: ________________________________ **Date:** ____________________

I certify that I have read and understand the above and that the information given on this form is accurate. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion

of this form. I authorize release of any information to process my insurance claim. I also authorize payment directly to the dentist of the insurance benefits otherwise payable to me. A copy of this signature is as valid as the original.

I have received notice of privacy practices

Signature of Patient/Legal Guardian:____ Date: ____________________