

WELCOME TO OUR OFFICE

Registration

		Date	
Patient's Name	Birthdate	Age	Soc.Sec.No.
Home Address	City/State	Zip	Phone
Person Financially Responsible	Relationship to You	Soc.Sec.No.	
Occupation	Employer	City/State	
Billing Address	City/State	Zip	Bus.Phone
Dental Insurance	Group/Plan No.	Referred By	
Spouse Name	Employer	Soc.Sec.No.	
Secondary Dental Insurance	Group/Plan No.	Ins.Co.Phone	

Dental History

Why have you come to the dentist today? _____

When was your last checkup? _____

When was your last full mouth x-ray? _____

What did you like best about the last dental office you visited? _____

What did you like least? _____

Are you currently in pain? Yes No
Have you experienced any problem with any previous dental work Yes No
Do you have frequent headaches? Yes No
Do you now or have you ever had pain/discomfort in your jaw joint? Yes No
Your current dental health is Good Fair Poor

How often do you brush each day? 1 2 3 4
Do you floss daily? Yes No Sometimes
Do your gums bleed? Yes No Sometimes
Have you ever had gum disease? Yes No
Do you have mobility in your teeth? Yes No
Does food sometimes get caught between your teeth? Yes No
Are your teeth sensitive to hot, cold, or anything else? Yes No
Have you lost any teeth? Yes No
If so, why? _____

Are you happy with the way your smile looks? Yes No
If not, what would you change? _____

Continued on Back

Medical History

Do you have a personal physician? Yes No

Physician's Name _____

Address _____

Phone No. _____ Date of last visit _____

Your current physical health is Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco products? Yes No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Latex	Y N Sulfa
Y N Codeine	Y N Penicillin	Y N Tetracycline
Y N Dental anesthetics	Y N Other antibiotics	Y N Other meds

Please list other medications that cause allergic reactions

Do you need premedication prior to dental work? Y N

For Women: Are you taking birth control pills? Y N

Are you pregnant? Unsure Yes No
week # _____

Are you nursing? Yes No

Are you taking any of the following?

Acetaminophen <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Pressure Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No	Recreational drugs <input type="checkbox"/> Yes <input type="checkbox"/> No
Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Remedies <input type="checkbox"/> Yes <input type="checkbox"/> No	Steroids/Cortisone <input type="checkbox"/> Yes <input type="checkbox"/> No
Antihistamines <input type="checkbox"/> Yes <input type="checkbox"/> No	Digitalis/Heart Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No
Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin/Diabetes Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	Tranquilizers <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Thinners <input type="checkbox"/> Yes <input type="checkbox"/> No	Nitroglycerin <input type="checkbox"/> Yes <input type="checkbox"/> No	

Are you taking any prescription/over the counter drugs not listed above? Yes No

If yes, please list each one: _____

Have you experienced the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Difficulty Breathing	Y N Herpes	Y N Severe Headaches
Y N Alcohol Abuse	Y N Drug Abuse	Y N High Blood Pressure	Y N Shingles
Y N Anemia	Y N Emphysema	Y N HIV+/- AIDS	Y N Sickle Cell
Y N Arthritis	Y N Epilepsy	Y N Hospitalized	Y N Sinus Problems
Y N Artificial Bones/Joints	Y N Fainting Spells	Y N Kidney Disorder	Y N Steroid Therapy
Y N Artificial Valves	Y N Fever Blisters	Y N Liver Disease	Y N Stroke
Y N Asthma	Y N Frequent Headaches	Y N Low Blood Pressure	Y N Thyroid Problems
Y N Blood Transfusion	Y N Glaucoma	Y N Mitral Valve Prolapse	Y N Tonsillitis
Y N Cancer	Y N Hay Fever	Y N Pacemaker	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Heart Attack	Y N Psychiatric Problems	Y N Ulcers
Y N Chicken Pox	Y N Heart Murmur	Y N Radiation Treatment	Y N Venereal Disease
Y N Colitis	Y N Heart Surgery	Y N Rheumatic Fever	Y N History of Canker Sores(ApthousUlcers) or Cold Sores
Y N Congenital Heart Defect	Y N Hemophilia	Y N Scarlet Fever	
Y N Diabetes	Y N Hepatitis	Y N Seizures	

If you answered Yes to any of the above, please explain: _____

I affirm that the information I have given today is correct to the best of my knowledge. I consent to whatever Dental Procedures and anesthetics are necessary for the treatment of the patient listed above.

Signature _____ Date _____

I agree to assume full Financial Responsibility for all treatment rendered. Signature _____ Date _____ I also agree to pay 1.5% interest on any balance over 30 days old.

Signature _____ Date _____