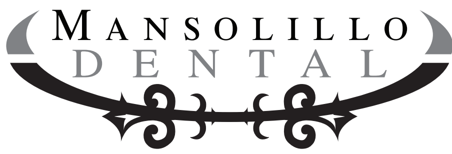


Patient Registration And Medical History

PATIENT INFORMATION

PATIENT'S NAME Last ______________ First ______________ Middle Initial ______

Sex: M F BIRTHDATE ______________ Age ______ Soc. Sec. # ______________

If Patient is a Minor, give Parent's or Guardian's Name ______________ TODAY'S DATE ______________

Who May We Thank for Referring You to our Office? ______________

Reason for this visit ______________

RESIDENCE Street ______________ Apt# ______ City / State ______________ Zip ______

Home Phone ______________ Cell Phone ______________ Work Phone ______________

E-MAIL ______________

Spouse / Partner Name ______________ Contact # ______________

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ______________ Insured's Soc. Sec. # ______________

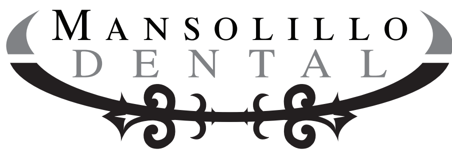
Insurance Co ______________ Insurance Co. Address ______________

Insured's Employer ______________ Group # ______________ Local # ______________

E-MAIL ______________

DENTAL HISTORY

	YES	NO		YES	NO
HOW LONG SINCE you have seen a dentist? ______			Are you having PROBLEMS now?	☐	☐
Last COMPLETE Dental Exam, Date: ______			What? ______		
Last FULL MOUTH X-RAYS Date: ______	16 Small Films or Panoramic				
Is your present dental health POOR?	☐	☐	Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐	Would you like to know more about PERMANENT REPLACEMENT?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐	Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐	Are your teeth SENSITIVE to hot, cold, sweets, pressure ? (circle)		
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐	Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐	Have you worn BRACES on your teeth (ORTHODONTICS)?	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐	Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐			



Patient Registration And Medical History

MEDICAL HISTORY

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what? ____________________		
Are you PREGNANT?	☐	☐

	YES	NO
What MEDICATIONS are you currently taking? ____________________		
Have you ever taken Fen-Phen/Redux?	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco?	☐	☐

Do you have any ALLERGIES to any MEDICATIONS? ____________________

PLEASE MARK YES OR NO IF YOU HAVE OR EVER HAD

	YES	NO
Heart Problems	☐	☐
When? ____________		
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Circulatory Problems	☐	☐
Nervous Problems	☐	☐
Radiation Treatment	☐	☐
When? ____________		
Artificial Heart Valves or Joints	☐	☐
When? ____________		
Recent Weight Loss	☐	☐
Back Problems	☐	☐
Diabetes	☐	☐

	YES	NO
Respiratory Disease	☐	☐
Epilepsy	☐	☐
Headaches	☐	☐
Hepatitis, Jaundice or Liver Disease	☐	☐
Cancer	☐	☐
When? ____________		
Psychiatric Care	☐	☐
Chronic Diarrhea	☐	☐
Allergies to Anesthetics	☐	☐
General Allergies	☐	☐
Blood Disease	☐	☐
Arthritis	☐	☐
Special Diet	☐	☐

	YES	NO
Swollen Neck Glands	☐	☐
Rheumatic Fever	☐	☐
Sinus Problems	☐	☐
"A.I.D.S." or Other Immunosuppressive Disorders	☐	☐
Stroke	☐	☐
When? ____________		
Ulcer	☐	☐
Venereal Disease	☐	☐
Chemical Dependence	☐	☐
Hemophilia	☐	☐

The above information is accurate & complete to the best of my knowledge & is only for use in my treatment, billing & processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

PATIENT Signature ____________________ Date: ____________
(Parent of Child)

DENTIST Signature ____________________