WELCOME TO OUR OFFICE

PATIENT REGISTRATION | **ALL INFORMATION IS CONFIDENTIAL** | **PLEASE PRINT**

The following information is required by our clinic to assist in proper diagnosis and treatment. Please feel free to ask our receptionist for help in completing this form.

PATIENT INFORMATION

Last Name:	First Name:	Initial:	Title: (Dr. Mr. Mrs. Ms.)

Mailing Address:	City:	Postal Code:

Date of Birth: (MMDDYY)	Home Phone:	Work Phone: (Ext)	Cell Phone:	Employer:

Health Care #:	Email:	How did you hear about us?

Emergency Contact and Phone #	Physician:	Phone:

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT

Last Name:	First Name:	Initial:	Title:	Relationship:

Mailing Address If Different than above:	City:	Postal Code:

Date of Birth: (MMDDYY)	Home Phone:	Work Phone: (Ext)	Cell Phone:	Employer:

PRIMARY DENTAL INSURANCE / SECONDARY DENTAL INSURANCE

PRIMARY DENTAL INSURANCE			SECONDARY DENTAL INSURANCE		
Name of Insured:		Date of Birth: (MMDDYY)	Name of Insured:		Date of Birth: (MMDDYY)
Employer		Insurance Carrier	Employer		Insurance Carrier
Group/Policy Number	Division	Certificate Number	Group/Policy Number	Division	Certificate Number
Maximum	Benefit Year	Other	Maximum	Benefit Year	Other

MEDICAL HISTORY: Please answer the following questions: (Please Circle)

Are you currently under the care of a physician?	yes	no	Are you aware of any medical problems?	yes	no
Are you currently taking any medication or drugs?	yes	no	*Women Only* Are you Pregnant?	yes	no
Do you have any allergies?	yes	no	Are you taking Birth Control Rx?	yes	no

Please provide a list of all medications/drugs taken and a list of all allergies on the reverse

Have you experienced any unusual reaction to the following? *(please circle)*

Local anaesthetic (freezing): Yes No	Aspirin: Yes No	Penicillin: Yes No	Latex: Yes No	Sulfa Drugs: Yes No

Do you have or have you had any of the following? (please circle) *example: High/Low Blood Pressure yes no*

Heart Murmur	yes	no	Asthma	yes	no	Rheumatic Fever	yes	no
Stomach Problems	yes	no	Hay Fever	yes	no	Hepatitis A/B/C	yes	no
Joint Replacement	yes	no	Cold Sores	yes	no	Diabetes	yes	no
Mental/Nervous Disorder	yes	no	Sinus Trouble	yes	no	Tuberculosis	yes	no
High/Low Blood Pressure	yes	no	Arthritis	yes	no	Venereal Disease	yes	no
Epilepsy/Seizures	yes	no	AIDS	yes	no	Hyper/Hypo Glycemia	yes	no
Stroke/Heart Problems	yes	no	HIV	yes	no	Thyroid Disease	yes	no
Drugs/Alcohol Addiction	yes	no	Jaundice	yes	no	Cancer	yes	no

Do you Bruise/Bleed easily or abnormally?	yes	no	Do you have frequent or severe Headaches?	yes	no
Do you smoke?	yes	no	Do you have any hearing difficulties?	yes	no

Please note the date of your joint replacement or heart/stroke problem

Do you have any disease, condition or problem you feel we should be aware of? *(Please Specify)*

TO AVOID COMPLICATIONS, PLEASE NOTIFY OUR OFFICE OF ANY CHANGES TO YOUR MEDICAL HISTORY

WELCOME TO OUR OFFICE

DENTAL HISTORY

Reason for Today's Visit:

How frequently do you see your dentist?: *(Please Circle)* 6 months 9 months Annually When something hurts or breaks

Former Dentist: Name:	Address:	Phone:
Date of your last visit:	Last Cleaning:	Last Examination:

Are any of your teeth sensitive to?:

	Cold: Yes No	Hot: Yes No	Sweet: Yes No	Other: Yes No

Do your gums bleed when?:

	Brushing: Yes No	Flossing: Yes No	Spontaneously: Yes No

Are you aware or have you been told that you clench or grind your teeth: Yes No

Do you have any emotional concerns about your dentist visit?: *(Please Circle)* Fear Discomfort Time Cost Embarrassment

Are you interested in or have you thought about any of the following regarding your teeth?: (Please Circle)

	Orthodontics (Braces)	Tooth Whitening (Bleaching)	Implants
	Bonding	Crowns (Caps)	Improving your Smile
	Closing Spaces between teeth	Sports Mouthguard	
	Replacement of Missing Teeth	Improved Gum Line	
	Repairing Chipped Teeth	Improving Breath Odor	

MEDICAL LISTING

Name of Medication:	Reason:	Dosage:

ALLERGIES: Please List All Allergies

INFORMED CONSENT/GENERAL RELEASE

I, the undersigned, state that I have provided an accurate and complete Medical / Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this Medical / Dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic as be necessary. I also understand that, I assume sole responsibility for any and all fees associated with the procedures and services.

Patient (Parent, Guardian) Signature:	*Date: (MMDDYY)*

If Parent or Guardian Please Print Name Here:

MEDICAL HISTORY UPDATE *If any changes, record in medical history*

Date	Same	Changed	Patient Signature	Comments	Staff Initial