STRAIT SMILES
FAMILY DENTISTRY

Date ______________________

ADULT REGISTRATION

Name (First)______________________________ Last______________________________ MI______

Birth Date______________ Gender___________ Social Security Number_____________________

Street Address____

City____________________________________ State______ Zip Code________________________

Home Phone_________________________________ Work Phone____________________________

Cell Phone___________________________________ Preferred contact number (Home / Work / Cell)

Patient Employer___________________ E-mail Address____

Do you prefer appointments to be confirmed by a text and/or e-mail? **Yes** **No** **Text** **E-mail**

Spouse's Name____ Birth Date__________________

In case of emergency, please notify____

Phone Number____________________________ Relation to Patient_____________________________

Person Responsible for this Account____

Whom may we thank for referring you____

DENTAL INSURANCE INFORMATION

Name of Dental Insurance____

Id Number (may be SSN)__________________________ Group Number____________________________

Name of Subscriber_________________________ Employer_____________________________________

Secondary Dental Insurance____

Id Number (may be SSN)__________________________ Group Number____________________________

Name of Subscriber ________________________ Employer_____________________________________

I hereby authorize payment of dental benefits made directly to Strait Smiles Family Dentistry.

____ ________________________

Signed (Insured Person) *Date*

Revised 5/19

DENTAL AND MEDICAL INFORMATION

Date _______________ Patient's Name ____

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

DENTAL INFORMATION

Date of last dental visit?_________Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely

Have you ever had any serious trouble associated with previous dental treatment? ❑ **YES** ❑ **NO**

Are you required or do you take pre-medication prior to dental treatment? ❑ **YES** ❑ **NO**

If yes, what are you prescribed and the reason for pre-medication: ____

Correct responses to the following statements will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

	Yes	*No*		*Yes*	*No*
It is important for me to keep my teeth?	❑	❑	I have had injury to my head, neck or jaw?	❑	❑
I am having dental pain at this time?	❑	❑	I have had orthodontic treatment (braces)?	❑	❑
I wear a removable dental appliance?	❑	❑	I have had oral surgery?	❑	❑
I am dissatisfied with the appearance of my teeth?	❑	❑	I have had my bite adjusted?	❑	❑
I clench my teeth while I am awake or asleep?	❑	❑	My teeth are sensitive to:	❑	❑
I bite my lips or cheeks frequently?	❑	❑	❑ Hot ❑ Sweets ❑ Cold ❑ Biting		
I smoke or use chewing tobacco?	❑	❑	I experience bad breath/taste?	❑	❑
Food tends to get caught between my teeth?	❑	❑	I get frequent blisters on my lips/mouth?	❑	❑
Has anyone in your family ever had gum treatment?	❑	❑	I have noticed my teeth loosening?	❑	❑
I have had periodontal treatment? If so, when:	❑	❑	I have had excessive bleeding following an extraction and/or cuts take longer to heal?	❑	❑
I do wear or have worn a bite guard appliance?	❑	❑	I get frequent swelling/lumps in my mouth?	❑	❑
I notice clicking of the jaw?	❑	❑	I use the following:	❑	❑
I notice pain (joint, ear, side of face)?	❑	❑	❑ Toothbrush ❑ Dental floss ❑ Fluoride rinse		
I notice difficulty in opening or closing?	❑	❑	How often do you brush?	❑	❑
I notice difficulty in chewing?	❑	❑	My gums often bleed while brushing?	❑	❑

MEDICAL INFORMATION

Physician name & address/phone: ____

Date of last physical exam: ____________________ Are you currently under the care of a physician? ❑ **YES** ❑ **NO**

If so, describe ____

<u>Prescription and Non-prescription Drug Information</u>

Please describe any current medical treatment INCLUDING ALL current drugs/medications and the reason you are taking the medication:

____

____

Do you have a history of taking drugs for osteoporosis or cancer therapy? ❑ **YES** ❑ **NO**

Commonly used agents: **<u>IV form</u>** ❑ Pamidronate (Aredia) ❑ Zoledronate (Zometa) (Reclast)

<u>Oral form</u> ❑ Alendronate (Fosamax) ❑ Ibandronate (Boniva) ❑ Risedronate (Actonel)

(Please complete reverse side)

Do you regularly take supplements or herbal medicines? ❑ **YES** ❑ **NO**

If yes, do you regularly take any of the following?

❑ Vitamin E >400 units ❑ Fish Oil >3g ❑ Echinacea ❑ Ephedra ❑Garlic
❑ St. John's Wort ❑ Kava Kava ❑ Ginseng ❑Valerian ❑Ginkgo Biloba

Have you recently stopped taking any herbs? ❑ **YES** ❑ **NO**

Have you substituted any herbs for prescription or over the counter drugs? ❑ **YES** ❑ **NO**

Please describe any pending surgeries, recent injuries or any other information we should be aware of that we have not discussed:

____

Please answer the following medical condition questions, filling in the blanks when necessary:

	Yes	***No***		***Yes***	***No***		***Yes***	***No***
<u>I have or I have had the following cardiovascular conditions:</u>			Leukemia	❑	❑	**<u>I am allergic to, or I have had any reactions to:</u>**		
			Tuberculosis	❑	❑			
			HIV infection	❑	❑			
Rheumatic fever	❑	❑	AIDS	❑	❑	Local anesthetic (Novocaine)	❑	❑
Heart murmur	❑	❑	Venereal disease	❑	❑	Penicillin, other antibiotics	❑	❑
Congenital heart defect	❑	❑	Stomach ulcers	❑	❑	Barbiturates, sedative or sleeping pills	❑	❑
Heart transplant	❑	❑	Reflux disease	❑	❑			
Heart surgery/Angioplasty	❑	❑	Glaucoma	❑	❑	Sulfa drugs	❑	❑
Vascular disease	❑	❑	Cancer	❑	❑	Aspirin	❑	❑
Stroke	❑	❑	Chemical dependency	❑	❑	Other pain meds	❑	❑
Pacemaker	❑	❑	Problems with mental health	❑	❑	Iodine	❑	❑
Prosthetic heart valve	❑	❑	Seizures	❑	❑	Latex gloves	❑	❑
Heart attack (heart trouble)	❑	❑	Joint replacement	❑	❑	Other:	❑	❑
High blood pressure	❑	❑	Type:					
Low blood pressure	❑	❑				**<u>I am or I have taken:</u>**		
Angina	❑	❑	Date:			Antibiotics/sulfa drugs	❑	❑
Other Cardio Problems Describe:	❑	❑	Orthopedic pins, rods, screws, prosthetic devices or implants	❑	❑	Antihistamines	❑	❑
						Aspirin or other pain meds	❑	❑
			Type:			Codeine	❑	❑
						Dilantin	❑	❑
<u>Other conditions:</u>			Date:			Insulin/Blood sugar drugs	❑	❑
Multiple Sclerosis	❑	❑	**<u>I have or I have had:</u>**			Blood thinners	❑	❑
Liver disease, jaundice	❑	❑	Chest pain upon exertion	❑	❑	Blood pressure medications	❑	❑
Hepatitis	❑	❑	Shortness of breath after exercise	❑	❑	Digitalis/Heart drugs	❑	❑
Diabetes	❑	❑	Ankle swelling	❑	❑	Nitroglycerine	❑	❑
Kidney trouble, dialysis	❑	❑	Shortness of breath lying down	❑	❑	Tranquilizers	❑	❑
Thyroid problems	❑	❑	Sores in the mouth	❑	❑			
Allergies	❑	❑	White lesions in the mouth	❑	❑	**<u>Women only:</u>**		
Asthma	❑	❑	Lumps or tumors in mouth\neck	❑	❑	I am pregnant	❑	❑
Hay fever	❑	❑	Persistent diarrhea/nausea/vomiting	❑	❑	I am nursing	❑	❑
Hives or skin rash	❑	❑	Fainting spells	❑	❑	I am on birth control pills	❑	❑
Arthritis, Rheumatism	❑	❑	Persistent cough or cough blood	❑	❑			
Anemia	❑	❑	Radiation or chemotherapy	❑	❑			
Hemophilia/bleeding disorders	❑	❑	Blood transfusion Date:	❑	❑			

To the best of my knowledge, the above information is complete and correct. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. *I understand that a 1.5% Service Charge may be assessed on the unpaid balance of 60 days and over, and also liable for legal and collection fees. I understand that I am responsible for payment in full upon completion of each procedure. My insurance will be billed, if applicable, however, I am responsible for all charges not covered by my insurance.*

____ _______________

Signature of patient or parent/guardian *Date*

(Please complete reverse side)

Revised 7/30/19