GENERAL PATIENT INFORMATION

Patient Registration

Patient Information

Full Name: _____

Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Sex: ☐ Male ☐ Female

SSN/ID: _____

Email Address: _____

Home Phone Number: _____

Cell Phone Number: _____

Drivers License

State: _____

Number: _____

Home Address:

Address: _____

City, State and ZIP: _____

Billing Address:

Address: _____

City, State and ZIP: _____

Work Information

Employer: _____

Occupation: _____

Work Phone Number: _____

Method of Contact: ☐ Phone ☐ Email ☐ Text Message ☐ Any of the previous ones

Emergency Contact:

Full Name: _____

Phone Number: _____

Relation: _____

How did you hear about our office?

Who may we thank for referring you? _____

GENERAL PATIENT INFORMATION

Financial Information

Patient's Payment Details – Guarantor (Person responsible for paying the bill)

Guarantor Name: _____

SSN/ID: _____

Relation to Patient: _____

Patient's Student Status

Student Status: _____

College: _____

College Address: _____

Primary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____

Date of Birth: _____

SSN/ID: _____

Employer: _____

Policy Number: _____

Group Number: _____

Coverage Type: ☐ Individual ☐ Family ☐ Prepaid / Capitation

Insurance Company: _____

Company Phone Number: _____

Company City, State, ZIP: _____

Secondary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____

Date of Birth: _____

SSN/ID: _____

Employer: _____

Policy Number: _____

Group Number: _____

Coverage Type: ☐ Individual ☐ Family ☐ Prepaid / Capitation

Insurance Company: _____

Company Phone Number: _____

Company City, State, ZIP: _____

Pharmacy Information

Name: _____

Address: _____

Pharmacy Phone Number: _____

Medicaid Number: _____

I authorize the dentist to release any information, including diagnosis, treatment plans/records and radiographs to third party payers and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the dental group or dentist benefits that are, otherwise, payable to me. I understand that my dental insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its payment and credit terms and policies.

Signature: _____

PATIENT MEDICAL HISTORY

Patient's Medical History

Physician Information

Physician's Full Name: _____

Address: _____

City, State and ZIP: _____

Are you currently under a physician's Care? ☐ Yes ☐ No

If Yes, for what?

Have you been hospitalized in the last two years? ☐ Yes ☐ No

If Yes, for what?

Are you taking any medication, drugs or pills? ☐ Yes ☐ No

If so, please list the names and dosages of each:

Do you Smoke? ☐ Yes ☐ No How Much? _____

Women Only

Are you pregnant? ☐ Yes ☐ No What is your due date? _____

Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Are you on Hormone Therapy? ☐ Yes ☐ No

Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

Medical Alerts

- ☐ Allergic to Penicillin
- ☐ Allergic to Tetracycline
- ☐ Allergic to Aspirin
- ☐ Allergic to Codeine
- ☐ Allergic to 'Novocaine'
- ☐ Allergic to Latex Rubber
- ☐ Pre-Medication required
- ☐ Mitral Valve Prolaspe
- ☐ Heart Problems
- ☐ Pacemaker
- ☐ HIV Positive
- ☐ Prior Hepatitis
- ☐ Other

Medical Conditions

- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Congenital Heart Problem
- ☐ Artificial Heart Valve
- ☐ Heart Surgery
- ☐ High/Low Blood Pressure
- ☐ Rheumatic Fever
- ☐ Anemia
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Stroke
- ☐ Deep Vein Clot
- ☐ Hemophilia
- ☐ Excessive Bleeding when Cut
- ☐ Sickle Cell Disease
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Scarlet Fever
- ☐ Thyroid Disease
- ☐ Parathyroid Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Hepatitis A or B
- ☐ Yellow Jaundice
- ☐ Cancer
- ☐ X-Ray or Cobalt Treatment
- ☐ Chemotherapy
- ☐ Ulcers
- ☐ Gastrointestinal Upset
- ☐ Acid Reflux
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Hay Fever
- ☐ Frequent Cough
- ☐ Rheumatism
- ☐ Arthritis/Gout
- ☐ Osteoporosis
- ☐ Swelling of Feet/Ankles
- ☐ Artificial Joint Replacement
- ☐ Psychiatric Care
- ☐ Epilepsy or Seizures
- ☐ Extreme Nervousness
- ☐ Fainting or Dizziness
- ☐ Hypoglycemia
- ☐ Hives
- ☐ Cold Sores/Fever Blisters
- ☐ Venereal Disease
- ☐ Herpes
- ☐ HPV (Human Papillary Virus)
- ☐ Cortisone Treatment
- ☐ Chemical Dependency

PATIENT DENTAL HISTORY

Patient's Dental History

What is your primary reason for seeking dental care?

_____

Previous Dentist Information

Dentist's Full Name: _____

City, State and ZIP: _____

Month and Year of Last Visit: _____

What was done at your last visit? _____

Date of Last full mouth x-rays: _____

Reason for leaving previous dentist: _____

How often do you visit the dentist? ☐ Annual Check Up ☐ Twice a Year Check Up

☐ Only when I have a problem ☐ Other

Please choose the appropriate answer

Are you nervous about receiving dental treatment? ☐ Yes ☐ No

Do you gag easily? ☐ Yes ☐ No

Have you had previous problems with dental care? ☐ Yes ☐ No

If so, please explain?

Are your teeth sensitive to hot, cold, pressure or sweets? ☐ Yes ☐ No

Do you have problems with teeth/fillings breaking? ☐ Yes ☐ No

Are you aware of an uncomfortable bite? ☐ Yes ☐ No

Do your gums feel tender and/or bleed? ☐ Yes ☐ No

Does food catch between your teeth? ☐ Yes ☐ No

Have you had periodontal (gum) treatments? ☐ Yes ☐ No

Do you get sores in or around your mouth? ☐ Yes ☐ No

Do you have regular headaches, earaches or neck pains? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you hear a "clicking" sound when you open/close your mouth? ☐ Yes ☐ No

Does your jaw ever get "stuck?" ☐ Yes ☐ No

Do you have a Temporomandibular (TMJ) jaw disorder? ☐ Yes ☐ No

Are you missing teeth that have not been replaced? ☐ Yes ☐ No

Have you had excessive bleeding after an extraction? ☐ Yes ☐ No

Have you had mouth sores that take long to heal? ☐ Yes ☐ No

Do you have any dental implants? ☐ Yes ☐ No

Do you wear dentures (partials or full)? ☐ Yes ☐ No

Do you have any crowns (caps) or bridges? ☐ Yes ☐ No

Do you chew tobacco? ☐ Yes ☐ No

Do you have a dry mouth? ☐ Yes ☐ No

Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No

Would you like your smile to look better? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

Do you regularly use dental floss? ☐ Yes ☐ No

Do you brush at least once daily? ☐ Yes ☐ No

Is there anything else that you would like us to know?

I authorize the use of my radiographs [x-rays] and/or photographs for educational and promotional use in seminars, publications and the dental office web site. ☐ Yes ☐ No

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. 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 completion of this form.

Signature: _____