ADULT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE			
NAME			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.			
BIRTH DATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			
CELL			
EMAIL			
EMPLOYER			
BUSINESS PHONE NO.	EXT.		
DRIVERS LICENSE #			

DENTAL INSURANCE	
PRIMARY CARRIER	
INSURANCE	
GROUP NO.	
ID NUMBER	
DATE OF BIRTH	DATE EMPLOYED
EMPLOYER	
EMPLOYEE SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
ID NUMBER	
DATE OF BIRTH	DATE EMPLOYED
EMPLOYER	
EMPLOYEE SOCIAL SECURITY NO.	

ACCOUNT INFORMATION		
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.	EXT.	
CELL		

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
REFERRED TO US BY		
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

Please turn over and sign

Patient Name

DENTAL HISTORY

Patient Account No. Medical Alert

Welcome! So that we may provide you with the best possible care
please complete both sides of this medical/dental history form.
All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays**_____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone_____

How often do you have dental examinations?_____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breath while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

_____

_____

(Please complete other side)

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? **Yes No If Yes, for what?** _____

Physician's Name _____ **Phone #** _____

Have you been hospitalized or had a major operation in past five years? **Yes No If Yes, why?** _____

Do you take any blood thinners or low dose aspirin? **Yes No If Yes, how often?** _____

Are you taking any medications, pills, or drugs? **Yes No** **If Yes, please list prescribed/over the counter meds:**

_____

_____

_____

_____

Have you ever taken or are you taking any bone-density medication (Fosamax, Boniva, Actonel or Any Other)? **Yes No**

Have you received a diagnosis for Obstructive Sleep Apnea? **Yes No** Do you use a CPAP machine? **Yes No**

Are you allergic to any of the following? (Circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs

Local Anesthetics Other: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatment	Yes No
Alzheimer's	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss/Gain	Yes No
Cancer	Yes No	Diet (Special/Restricted)	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Yellow Jaundice	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Allergies or Hives	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Bruise Easily	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Fever Blisters	Yes No	Kidney Problems	Yes No	Psychiatric Care	Yes No
Blood Transfusion	Yes No	Glaucoma	Yes No	Leukemia	Yes No	Stroke	Yes No
Dementia	Yes No	Hay Fever	Yes No	Liver Disease	Yes No	Swelling of Limbs	Yes No
Chemotherapy	Yes No	Heart Attack/Failure	Yes No	Low Blood Pressure	Yes No	Thyroid Disease	Yes No
Chest Pains	Yes No	Heart Murmur	Yes No	Lung Disease	Yes No	Tuberculosis	Yes No
Chronic Cough	Yes No	Heart Pacemaker	Yes No	Mitral Valve Prolapse	Yes No	Tumors or Growths	Yes No
Cold Sores	Yes No	Heart Trouble/Disease	Yes No	Osteoporosis	Yes No	Ulcers	Yes No

Do you have or have you had any disease, condition, or problem not listed? **Yes No** **If Yes, please list:** _____

_____

Women are you: Pregnant? **Yes No If Yes, How many months?** ____ Nursing? **Yes No** Taking birth control? **Yes No**

To the best of my acknowledgement, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes.

Parent/Guardian Signature _____ **Date** _____