Patient Registration

Date of Completion:

Last Name: _____ First Name: _____ MI: ___ Date of Birth: _____ Age: ___

Sex: M ☐ F ☐ Soc. Sec. #: _____ Relationship Status: Single ☐ Married ☐ Separated ☐ Widow ☐

Mailing Address: _____ City: _____ State: ___ Zip Code: _____

Email: _____ Home Phone: _____ Cell Phone: _____

Driver's License #: _____ Employer: _____ Work Phone: _____ Occupation: _____

Are you a full time student? YES ☐ NO ☐ *If patient is a minor, Mother's DOB:* _____ *Father's DOB:* _____

Name of Parent: _____ Parent Soc. Sec. #: _____

Parent Employer: _____ Parent Phone: _____

Person Responsible for Account: _____ Relationship: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

If you are filling out this form on behalf of another person, please indicate the following:

Name: _____ Relationship: _____

How did you hear about us? ☐ Mail ☐ Social Media ☐ Insurance ☐ Internet ☐ Family/Friend/Coworker

☐ Other _____ *Who can we thank for your visit?* _____

Dental Insurance Information (Primary Coverage)

Insured's Name: _____

Insured's Employer: _____

Insured's DOB: _____

Ins. Company: _____

Ins. Address: _____

Ins. Phone #: _____

Group #: _____ Local #: _____

Dental Insurance Information (Secondary Coverage)

Insured's Name: _____

Insured's Employer: _____

Insured's DOB: _____

Ins. Company: _____

Ins. Address: _____

Ins. Phone #: _____

Group #: _____ Local #: _____

Pharmacy Information:

Name: _____ Address: _____ Phone: _____

Dental History

On a scale of 1-10, with 10 being the highest rating:
How important is your dental health to you?
Where would you rate your current dental health?
Where do you want your dental health to be?

What would you like to <u>change</u> about your smile?
☐Color ☐Bite ☐Chipped Teeth ☐Spaces
☐Crowding ☐Smile Makeover ☐Missing Teeth
☐Whiter Teeth ☐ Size/Shape of Teeth

Please share the following dates:
Your last cleaning:_____ Your last oral cancer screening:_____ Your last complete x-rays:_____

What is the most important thing to you about your *future smile and dental health*?_____

What is the most important thing to you about your *dental visit today*?_____

Why did you leave your previous dentist?_____

Name of your previous dentist:_____

Please check the following conditions that apply to you:

Appearance	**Function**	**Habits**	**Previous Comfort:**
☐ Discolored Teeth	☐ Grinding/clenching	☐ Thumb sucking	☐ Nitrous Oxide
☐ Worn Teeth	☐ Headaches	☐ Nail biting	☐ Oral Medication
☐ Misshapen teeth	☐ Jaw Joint (TMJ) pain	☐ Cheek/lip biting	☐ IV Sedation
☐ Crooked teeth	☐ Jaw Joint (TMJ) click/pop	☐ Chewing on ice, etc.	
☐ Spaces	☐ Bad Bite		
☐ Overbite	☐ Speech Impediment	**Sleep Pattern or Conditions**	**Please list any family history of any conditions marked:**
☐ Flat teeth	☐ Mouth Breathing	☐ Sleep Apnea	
	☐ Sore Neck/Shoulders	☐ Snoring	
Pain/Discomfort	☐ Difficulty Opening/Closing	☐ Daytime Drowsiness	
☐ Sensitivity	☐ Difficulty Chewing	☐ Bed wetting (children)	
☐ Pressure			
☐ Broken Teeth	**Periodontal (Gum) Health**	**Social**	
☐ Broken Fillings	☐ Bleeding, Swollen	☐ Tobacco; Freq.:	
☐ Dry Mouth	☐ Bad Breath	☐ Alcohol; Freq.:	
☐ Oral Ulcers	☐ Loose/shifted teeth	☐ Drugs; Freq.:	
☐ Food Traps	☐ History of gum disease		

Have you ever undergone orthodontic (braces) treatment? ☐YES ☐NO

If you answered "yes",

Do you currently wear retainers? ☐YES ☐NO
What type of orthodontic treatment did you receive? ☐ Braces ☐ Clear Aligners ☐ Combo
Are you happy with the outcome? ☐ YES ☐ NO

Medical History

Please check any conditions that you have or have had in the past:

Cancer	**Endocrinology**	**Musculoskeletal**	**Respiratory**	**Medical Allergies**
Type:	☐ Diabetes	☐ Arthritis	☐ Asthma	☐ Penicillin
☐ Chemotherapy	☐ Hepatitis A/B/C	☐ Artificial Joints	☐ Emphysema	☐ Codeine
☐ Radiation	☐ Jaundice	☐ Jaw Joint Pain	☐ Sinus Problems	☐ Latex
Cardiovascular	☐ Kidney Disease	☐ Rheumatoid Arthritis	☐ COPD	☐ Local Anesthetics
☐ Angina (Chest Pain)	☐ Liver Disease	☐ Degenerative Disease	☐ Sleep Apnea	☐ NSAID's
☐ Artificial Heart Valve	☐ Thyroid Disease		☐ Tuberculosis	**Other Allergies**
☐ Heart Conditions		**Neurological**		☐
☐ Heart Surgery	**Gastrointestinal**	☐ Anxiety	**Viral Infections**	
☐ High/Low Blood Pressure	☐ Stomach Ulcers	☐ Depression	☐ AIDS	**Additional Comments:**
☐ Mitral Valve Prolapse	☐ Gastrointestinal Disease	☐ Dizziness	☐ HIV Positive	
☐ Pacemaker		☐ Drug/Alcohol Addiction	☐ HPV	
☐ Rheumatic Fever	**Hematologic/Lymphatic**	☐ Fainting		
☐ Scarlet Fever	☐ Anemia	☐ Seizures	**Reproductive**	
☐ Stroke	☐ Blood Disorders	☐ Psychiatric Illness	☐ Pregnant	
	☐ Bruise Easily		☐ Nursing	
	☐ Excessive Bleeding		☐ Birth Control	

Are you under the care of a physician? ☐ YES ☐ NO If yes, please explain: _____

Physician Name: _____ Address: _____ Phone #: _____

Have you had a serious illness, operation, or hospitalization in the past 5 years**?** ☐ YES ☐ NO

If yes, please explain: _____

Are you taking or have you recently taken any prescription or over the counter medications? ☐ YES ☐ NO

If yes, please list all and why, including natural and/or dietary supplements: _____

Have you ever taken any medication for Osteopenia/Osteoporosis or Bone Disease? ☐ YES ☐ NO

If yes, please list medications: _____

Have you ever had surgery? ☐ YES ☐ NO If yes, what type: _____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____ _____

Signature of Patient/Legal Guardian *Print Name* *Date* *Dentist Signature*