

Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth (Age)		Social Security Number	
Patient's Address			City	State	Zip
Home Phone		Mobile Phone	Email Address		
Referred by					

Patient Employer/School Information

Employer/School		Occupation	Employer/School Phone		
Employer/School Address			City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient
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Billing and Insurance

Primary Dental Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School			
Insured's Name (as it appears on insurance card or ID)		Relation to Patient		Insured's Phone Number	
Insured's Address		City	State	Zip	
Insured's Social Security Number	Insured's Birthdate				

Secondary Dental Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School		Insured's Social Security Number	
Insured's Name (as it appears on insurance card or ID)		Relation to Patient		Insured's Phone Number	

Responsible Party

Billing Name (if other than patient)		Phone	Relation to Patient		
Address		City	State	Zip	

Signature of Patient or Authorized Guardian

Date

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

Current Medications

Are you currently taking any blood thinners?

Yes No

What medications are you currently taking?

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dental History

When was your last dental exam?

Date _____

When were your last dental x-rays taken?

Date _____

How often do you brush?

times/day _____

How often do you floss?

times/day _____

Do you grind your teeth?

Yes No

Have you ever had orthodontic (braces) treatment?

Yes No

Past Medical History

Have you ever had any of the following?

- Alcoholism
- Allergies
- Anemia
- Anxiety Disorder
- Arthritis
- Asthma
- AIDS / HIV
- Bleeding Disorder
- Blood Disease
- Blood Transfusion
- Bowel Disorder
- Cancer
- Diabetes
- Depression
- Eating Disorder
- Epilepsy
- Hay Fever
- Heart Disease
- Heart Problems
- Hepatitis - A, B, or C
- High Blood Pressure

Lifestyle Factors

Have you ever smoked?

Yes No # of years _____ # packs/day _____

Do you smoke now?

Yes No # packs/day _____

Do you use recreational drugs?

Yes No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

Allergies

Are you allergic to any of the following?

- Adhesive Tape
- Barbiturates (Sleeping Pills)
- Codeine
- Antibiotics
- Aspirin
- Sulfa
- Latex
- Iodine
- Local Anesthetics

Do you have any other allergies?

Name	Reaction
_____	_____
_____	_____

Hospitalizations & Surgeries

Reason	Date
_____	_____
_____	_____
_____	_____

Have you ever had periodontal (gum) treatments?

Yes No

Do you have any of the following?

- Bad Breath
- Bleeding Gums
- Blisters on Mouth
- Broken Fillings
- Clicking Jaw
- Dentures
- Difficulty Opening or Closing
- Dry Mouth
- Difficulty Chewing
- Ear Pain
- Jaw Pain
- Loose Teeth
- Mouth Pain
- Mouth Sores
- Partialis
- Sensitivity to Cold
- Sensitivity to Heat
- Sensitivity to Sweets
- Sensitivity to Pressure
- Swollen Gums

- High Cholesterol
- Joint Disorder
- Kidney Disorder
- Liver Disorder
- Lung Disease
- Lupus
- Measles
- Migraines
- Osteoporosis
- Pacemaker
- Rheumatic Fever
- Sinus Problems
- Skin Disorder
- Stroke
- Stomach Ulcer
- Substance Abuse
- Thyroid Disorder
- Tuberculosis
- Venereal Disease

Women Only

Are you pregnant?

Yes No

Are you breastfeeding?

Yes No

What is your method of birth control?
