Patient Registration Form

Mrs.
Ms.
Dr.
Mr._____ SS#_____ Birthdate_____
Address_____ City_____ State___ Zip_____
Phone: Home _____ Bus._____ Cell_____
e-mail_____Spouse's Name_____
Children's names_____
Your employer _____ Occupation_____
Dental Insurance Co._____Name of/relation to insured_____
Who referred you to this office?_____
Why do you seek treatment at this time?_____
Are you pleased with your teeth (function/cosmetics)?_____
_____
Date of last dental cleaning_____ Date of last complete set of x-rays_____
Medical doctor_____ Phone_____ Specialty_____
Current Medications_____

Check YES or NO if you have had any of the following:

	Yes	No		Yes	No
Periodontal (gum) treatment	☐	☐	Hip/Joint/Valve replacement	☐	☐
Orthodontic treatment	☐	☐	Oral surgery	☐	☐
Tooth grinding habit	☐	☐	Radiation therapy	☐	☐
Root canal therapy	☐	☐	Bleeding gums	☐	☐
Removable dentures	☐	☐	TMJ problem	☐	☐
Frequent headaches	☐	☐	Dental phobia	☐	☐
Psychiatric care	☐	☐	Liver disease	☐	☐
Epilepsy	☐	☐	Hepatitis/jaundice (A/B/C)	☐	☐
Pain in the ear region	☐	☐	HIV/AIDS	☐	☐
Glaucoma	☐	☐	Venereal disease	☐	☐
Cosmetic surgery	☐	☐	Diabetes	☐	☐
Abnormal blood pressure	☐	☐	Kidney disease	☐	☐
Heart condition	☐	☐	Pregnant	☐	☐
Mitral valve prolapse	☐	☐	Substance dependence	☐	☐
Rheumatic fever	☐	☐	Other _____		
By-pass surgery	☐	☐	Allergy to:		
Pacemaker	☐	☐	Medications	☐	☐
Bleeding problem	☐	☐	Penicillin	☐	☐
Asthma	☐	☐	Local anesthesia	☐	☐
Arthritis	☐	☐	Nickel	☐	☐
Stroke	☐	☐	Other	☐	☐

_____
Do you smoke?_____ How much?_____ How long? _____
Emergency contact_____ Relationship_____

Signature_____Date_____