Patient Registration Form

PATIENT INFORMATION

First Name		Last Name					
How do you prefer to be addressed?							
Address							
City		State		ZIP Code			
Gender	Male Female	Birth Date		Age		SS #	
Marital Status	Single Married Widow Separated Divorced						
Email		Home Phone					
Cell Phone		Work Phone					
Occupation		Employer					
Employer's Address		City		State			
Student Status	Full Time Part Time	School Name					
City		State					
Whom may we thank for referring you to our office?							

If the person responsible for this patient's account is different from the patient or if patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information".

Name of Responsible Party		Relationship to Patient					
Mailing Address		City		State		ZIP Code	
Gender	Male Female	Birth Date		Age		SS #	
Marital Status	Single Married Widow Separated Divorced						
Home Phone		Work Phone					
Occupation		Employer					
Employer's Address		City		State		ZIP Code	

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Policy Holder's Name							
Relationship to Patient		Date of Birth		SS #			
Employer		Employee Address					
City		State		ZIP Code			
Insurance Company Name							
Insurance Company Address							
City		State		ZIP Code			
Group #		Policy ID #					

SECONDARY INSURANCE INFORMATION

Policy Holder's Name							
Relationship to Patient		Date of Birth		SS #			
Employer		Employee Address					
City		State		ZIP Code			
Insurance Company Name							
Insurance Company Address							
City		State		ZIP Code			
Group #		Policy ID #					

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HEALTH HISTORY

ANSWERS TO THE FOLLOWING QUESTIONS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

Have you or any member of your family been seen by us before?				Yes	No
If yes, which family member(s)?					
Date of Last Physical Examination		Physician Name			
Date of Last Dental Examination		Date of Last Dental X-rays			
Previous Dentist's Name		City/State			
Are you having pain or discomfort at this time?				Yes	No
Do you feel nervous about having dental treatment?				Yes	No
Have you ever had a bad experience in a dental office?				Yes	No
Is there anything you dislike about your smile?				Yes	No
Is there anything you would like to speak with the Doctor about in private?				Yes	No
Have you been a patient in the hospital during the past two years?				Yes	No
Have you been under care of a medical doctor during the past two years?				Yes	No
Have you taken any medications or drugs in the past two years?				Yes	No
Are you taking any vitamins, herbal supplements or "cures"?				Yes	No
Have you ever had any excessive bleeding requiring special treatment?				Yes	No

Have you had or do you currently have the following:

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding			Glaucoma			Pacemaker		
Alcohol Abuse			HIV+ / AIDS			Pain in Jaw Joints		
Anemia			Heart Attack / Failure			Psychiatric Condition		
Angina Pectoris			Heart Problems			Radiation Therapy		
Arthritis			Heart Surgery *			Rheumatic Fever		
Artificial Heart/or Valves *			Hemophilia			Sickle Cell Disease		
Artificial Joints *			Hepatitis A			Sinus Problems		
Asthma			Hepatitis B			Smoke or Tobacco		
Cancer-Chemotherapy			Hepatitis C			Steroid Treatment *		
Cold Sores			High Blood Pressure			Stroke		
Congenital Heart Disease/Defect*			Infective Endocarditis *			Thyroid Problems		
Diabetes			Irregular Heart Beat			Tuberculosis		
Difficulty Breathing			Jaundice			Ulcers		
Drug Abuse			Kidney Problems			Venereal Disease		
Eating Disorder			Liver Disease			Dry Mouth		
Emphysema			Low Blood Pressure			Frequent Headaches		
Epilepsy or Seizures			Mitral Valve Prolapse					
Fainting Spells			Osteoporosis					

*Antibiotic pre-medication may be required prior to your appointment.

Do you have any other conditions /problems not covered above? If yes, please list below.

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MEDICATIONS

Please list all medications that you are currently taking.

Name of Pharmacy	

ALLERGIES/REACTIONS

Are you allergic to, or had a reaction to any of the following:

	Yes	No		Yes	No		Yes	No
Aspirin			**Erythromycin**			**Metals**		
Codeine			**Jewelry**			**Penicillin**		
Dental Anesthetics			**Latex**			**Tetracycline**		

Do you have any other allergies/reactions not covered above? If yes, please list below.

DENTAL / MEDICAL QUESTIONS

Have you ever experienced any of the following problems with your jaw?

	Yes	No		Yes	No
Clicking			**Pain in or around your ears**		
Difficulty opening or closing			**Difficulty chewing**		
Do you have a history of trauma to your jaw?			**Have you ever been diagnosed with TMJ/TMD?**		

Do you currently have any problems listed below?

	Swelling		**Bad Taste**		**Bleeding Gums**		**Loose Teeth**
Sensitive to:							
	Hot		**Cold**		**Biting/Pressure**		**Sweets**

Do you have any sores, lumps, or growths in or near your mouth?	**Yes**	**No**
Have you ever had difficult extraction's in the past?	**Yes**	**No**
Have you ever had prolonged bleeding following extraction's?	**Yes**	**No**
Are there now any growths or sores in or around your mouth?	**Yes**	**No**
Do you habitually clench or grind your teeth during the day or night?	**Yes**	**No**
Problem with bad breath (Halitosis)?	**Yes**	**No**
Do you have any trouble chewing?	**Yes**	**No**
Does food collect between your teeth?	**Yes**	**No**
Have you ever had instructions on oral hygiene?	**Yes**	**No**
Have you ever taken Redux or Pondimin (Fen Phen)?	**Yes**	**No**
Have you ever been told you have gum problems?	**Yes**	**No**

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Have you ever needed to see a periodontist?	**Yes**	**No**
Do you now have bleeding gums or any other gum condition?	**Yes**	**No**
Is there anything related to your medical or dental history that you have not listed above?	**Yes**	**No**
If yes, please explain.		

FOR WOMEN ONLY					
Are you pregnant now?	**Yes**	**No**	**If yes, what is your due date?**		
Are you currently breast feeding?	**Yes**	**No**	**Are you taking oral contraceptives?**	**Yes**	**No**

WARNING: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control.

FORM COMPLETION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise pay able to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature (Parent or Guardian if minor)**:**		**Date:**	