PATIENT REGISTRATION

Patient's Name _____ Birth Date _____

Single ☐
Widowed ☐
Married ☐
Divorced ☐
Separated ☐

Name of Spouse _____ Birth Date _____

If a child, parent's name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ What is the best way to contact you? _____

Patient (or Parent if a Child) Employed by _____ Phone _____

Business Address _____

Present Position _____ How Long Held _____

Spouse (or Parent if a Child) Employed By _____ Phone _____

Business Address _____

Present Position _____ How Long Held _____

Purpose of this Appointment _____

In Case of Emergency, Who Should Be Notified _____ Phone _____

Person Responsible for this Account _____ Financial Institution _____

Social Security # _____ Driver's License # _____

Spouse's Social Security # _____ Spouse's Driver's License # _____

If Using Charge Card, Name _____ Card No. _____ Exp. Date _____

Name of Insurance Company _____

Policy No. _____ Group No. _____

If Spouse has Insurance, Name of Insured _____

Name of Insurance Company _____

Policy No. _____ Group No. _____

Whom May We Thank for Referring You _____

Comments: _____

I acknowledge and agree that a service charge per month will be changed on all balances remaining unpaid after 90 days from the date said amounts are incurred. I understand that I am responsible for all costs of dental treatment.
In the event of default and referral to an attorney or collection agency. I agree to pay all costs of collection including reasonable attorneys' fees. I understand that the above information is given for the purpose of obtaining credit and I certify that, to the best of my knowledge, the above information is complete and accurate as of the date of this application.

Signature _____ Date _____

PATIENT MEDICAL HISTORY

Physician_____ Office Phone _____ Date of Last Exam_____

1. Are you under medical treatment now? ❑ Yes ❑ No
   If yes, what condition: _____
2. Have you ever been hospitalized for any surgical operation or serious illness? ❑ Yes ❑ No
3. Are you taking any medication(s) including non-prescription medicine? ❑ Yes ❑ No
   If yes, what medications are you taking: _____
   _____
   _____
4. Do you use tobacco? ❑ Yes ❑ No
5. Do you use alcohol? ❑ Yes ❑ No
6. Do you use cocaine or other drugs? ❑ Yes ❑ No
7. Are you wearing contact lenses? ❑ Yes ❑ No
8. Are you allergic to or have you had any reactions to the following?
   - Local anesthetics (e.g. novocaine) ❑ Yes ❑ No
   - Barbiturates ❑ Yes ❑ No
   - Aspirin ❑ Yes ❑ No
   - Penicillin or Other Antibiotics ❑ Yes ❑ No
   - Sedatives ❑ Yes ❑ No
   - Sulfa Drugs ❑ Yes ❑ No
   - Iodine ❑ Yes ❑ No
   - Codeine ❑ Yes ❑ No
   - Latex ❑ Yes ❑ No
   - Other ❑ Yes ❑ No
9. Women only
   - a) Are you pregnant or think you may be pregnant? ❑ Yes ❑ No
   - b) Are you nursing? ❑ Yes ❑ No
   - c) Are you taking birth control pills? ❑ Yes ❑ No

EXISTING OR PREVIOUS CONDITIONS

10. Do you have or have you had any of the following?

Aids or HIV Infection	❑ Yes ❑ No	Epilepsy/Convulsions	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Fainting/Seizures	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No
Angina	❑ Yes ❑ No	Frequently Tired	❑ Yes ❑ No	Mental Disorders	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Hay Fever/Allergies	❑ Yes ❑ No	Nervous Disorders	❑ Yes ❑ No
Bleeding Disorder	❑ Yes ❑ No	Head Injuries	❑ Yes ❑ No	Radiation Therapy	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Recent Weight Loss	❑ Yes ❑ No
Bruise Easily	❑ Yes ❑ No	Heart Attack	❑ Yes ❑ No	Respiratory Problems	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Heart Disease	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Cardiac Pacemaker	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Sexually Transmitted Disease	❑ Yes ❑ No
Chest Pains	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Sinus Problems	❑ Yes ❑ No
Cold Sores/Fever Blisters	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Stomach Troubles/Ulcers	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Dizziness	❑ Yes ❑ No	Joint Replacement or Implant	❑ Yes ❑ No	Swollen Ankles	❑ Yes ❑ No
Easily Winded	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Thyroid Problem	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Leukemia	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No

OTHER MEDICAL CONDITIONS: _____

COMMENTS: _____

_____

PATIENT DENTAL HISTORY

1. Do your gums bleed while brushing or flossing? ❑ Yes ❑ No
2. Are your teeth sensitive to hot or cold liquid foods? ❑ Yes ❑ No
3. Are your teeth sensitive to sweet or sour liquid foods? ❑ Yes ❑ No
4. Do you feel pain to any of your teeth? ❑ Yes ❑ No
5. Do you have any sores or lumps in or near your mouth? ❑ Yes ❑ No
6. Have you had any head, neck or jaw injuries? ❑ Yes ❑ No
7. Have you experienced any of the following problems in your jaw?
   - a) Clicking? ❑ Yes ❑ No
   - b) Pain (joint, ear, side of face)? ❑ Yes ❑ No
   - c) Difficulty in opening or closing? ❑ Yes ❑ No
   - d) Difficulty in chewing? ❑ Yes ❑ No
8. Do you have frequent headaches? ❑ Yes ❑ No
9. Do you clench or grind your teeth? ❑ Yes ❑ No
10. Do you bite your lip or cheeks frequently? ❑ Yes ❑ No
11. Have you had any difficult extractions in the past? ❑ Yes ❑ No
12. Have you had any orthodontic work? ❑ Yes ❑ No
13. Have you had prolonged bleeding following extractions? ❑ Yes ❑ No
14. Have you had instruction on correct method of brushing your teeth? ❑ Yes ❑ No
15. Have you had instruction on the care of your gums? ❑ Yes ❑ No
16. Do you wear dentures or partials? ❑ Yes ❑ No
17. Is there anything you would like to change about your smile? ❑ Yes ❑ No
    If yes, what? _____

CERTIFICATION OF ACCURACY

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.

Patient, Parent or Guardian: _____ Date:_____