Patient Registration

Date _____

Patient Name _____ Birthdate _____ Age_____
First Middle Last

SS#_____DL#_____ Occupation _____Work # (____) _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Spouses Name: _____ Work # (___) _____

Home Address_____ Zip _____

Home Number (____) _____ Cell Phone (___) _____ E- Mail _____

Preferred method of contact: ❑ Home ❑ Work ❑ Cell ❑ E-mail ❑ Text

Is there anyone you would like to have access to your medical and dental information?_____

Employer Name and Address _____

Person Responsible for Account_____Relationship _____

Social Security # _____DL#_____Home # (___) _____

Home Address (if different)_____State_____Zip_____

Responsible Party Employer & Address_____State_____Zip_____

Occupation_____Work # (___) _____

Referred By_____Physician_____

Do you have Dental Insurance? ❑ Yes ❑ No With Whom?_____

Contact in case of Emergency _____Relationship_____

Address_____State_____Zip_____Phone_____

What are your concerns? *Mark all that apply:* ❑ Routine Checkup ❑ Cleaning ❑ Your General Health ❑ Appearance ❑ Pain Avoidance ❑ Cavities ❑ Losing Teeth ❑ Oral Cancer ❑ Gum/Periodontal Disease ❑ Wasting/Exceeding Dental Insurance Limits

Are you currently having a problem? _____

Medical Health History

1. Have there been any changes in your health since your last visit? ❑ Yes ❑ No
   If yes explain: _____
2. Are you currently under the care of a physician? ❑ Yes ❑ No
   Physician's Name:_____ Reason:_____
3. Are you taking any medications including Aspirin? ❑ Yes ❑ No List:_____

_____

_____

4. Are you allergic to any of the following: ❑ Penicillin ❑ Latex ❑ Sulfur ❑ Codeine ❑ Aspirin ❑ Novocain ❑ Other:_____

5. Has your physician ever informed you that you have or had?

❑ Heart Ailment / Disease	❑ Rheumatic Fever	❑ Stroke	❑ Asthma / Hay Fever
❑ Mitral Valve Prolapse	❑ Blood Disease	❑ Liver Disease	❑ Psychiatric Treatment
❑ High / Low Blood Pressure	❑ Kidney Disease	❑ Diabetes	❑ Venereal Disease
❑ Respiratory Disease	❑ Tumors or Growths	❑ Glaucoma	❑ Syphilis
❑ Stomach / Intestinal Disease	❑ Epilepsy / Convulsions	❑ Tuberculosis	❑ HIV+ / AIDS
❑ Thyroid Trouble / Goiter	❑ Abnormal Bleeding	❑ Eczema / Hives	❑ Osteoporosis
❑ Anemia / Leukemia / Low Platelets	❑ Rheumatism or Arthritis	❑ Fainting / Dizziness	❑ Other
❑ Cancer	❑ Prostate Trouble	❑ Hepatitis	_____
❑ Pregnant How long _____	❑ Breast Feeding	❑ Taking Birth Control	

❑ Pacemaker / Organ / Valve / Joint / Replacement or Implant: Date/Type: _____

❑ Surgeries past 5 years: _____

Additional Information: _____

Physician: _____ Date: _____

Do you smoke or use smokeless tobacco? ❑ Yes ❑ No

Do you have any other medical condition(s) we should beware of? _____

Dental Health History

What concerns you most about your dental health?_____

_____

Do you have Pain in your mouth? If yes, have you had treatment? ❑ Yes ❑ No
If so Where?_____ How long?_____

When was your last dental exam?_____ Last Complete set of x-rays?_____

Whom may we contact to get copies of your most recent x-rays?_____

When were your teeth last professionally "Cleaned"?_____
Do your gums bleed? ❑ Yes ❑ No Have you ever been told that you have Gum Disease? ❑ Yes ❑ No

If yes, have you had treatment? ❑ Yes ❑ No If yes, how long ago?_____

If no, why not?_____

If you have any missing teeth, were they replaced? ❑ Yes ❑ No If yes, have they been replaced? (check one or more)
❑ Complete Denture ❑ Removable Partial Denture ❑ Fixed Bridge ❑ Implant ❑ Other_____

If no, why were they not replaced?_____
Are you satisfied with the fit and appearance? ❑ Yes ❑ No

If no, what is it you don't like about them?_____
Are you happy with the appearance of your teeth? ❑ Yes ❑ No

If no, what don't you like?_____
Do you have any other dental condition of which we need to be aware? ❑ Yes ❑ No

If yes, please explain:_____
Have you ever had your sleep evaluated or had a sleep test? ❑ Yes ❑ No If yes, how long ago? _____
Have you ever been told to wear Continuous Positive Airway Pressure (CPAP)? ❑ Yes ❑ No
If yes, are you currently wearing your CPAP? ❑ Yes ❑ No
Have you ever been told that you snore or are you aware of any snoring? ❑ Yes ❑ No

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How did you find out about our office? ❑ Relative or Spouse ❑ Drive By ❑ Internet ❑ Location
❑ Referral – Whom may we thank for referring you?_____

What is it about coming to the dentist that you most dislike?_____
Would you like Nitrous Oxide (laughing gas) during your treatment? (there is an additional fee for this service). ❑ Yes ❑ No
If you had to choose between the following for your dental care, which would you choose? (check one)
❑ Appearance ❑ Function ❑ Cost
Please check one of the following phrase which best describes your approach to Dental Needs:
❑ If it ain't broke, don't fix it.
❑ I'd like to try and prevent issues from happening. I plan on keeping my teeth for a long time.
❑ I'll let you know when it hurts. We can do something then.
Would you prefer to have your treatment completed in a few long appointments? ❑ Yes ❑ No
Would you be available on a short notice basis for your appointments? ❑ Yes ❑ No
May we call your place of employment to make or confirm your appointments? ❑ Yes ❑ No
What can we do to make your dental appointment as pleasant as possible?_____

_____

Initial

_____ **I acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices."**

_____ **I Understand That Payment Is Due at Time of Service.**

I will pay today by: ❑ CASH ❑ CHECK ❑ CREDIT CARD ❑ OTHER

Signature: _____ Date: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA.