Date

PATIENT REGISTRATION

Patient's Name_____ Birthdate_____ Sex ❒ M ❒ F

Mailing Address_____ Home Phone _____
Street City Zip

Physical Address_____Patient's Cell_____

Patient's Employer_____Work Phone_____DL# _____

Soc. Sec. No._____ Marital Status ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed

Name of Spouse_____Spouse's Soc. Sec. No. _____

Spouse's Employer_____Who May We Thank For Referring You _____

Nearest Neighbor or Relative's Name, Address, and Phone No._____

Who Will Pay This Account? (Whose name will appear on the Billing Statement)

❒ Self ❒ Spouse ❒ Parent or Guardian

If you checked "Self" please Skip Next Section and Continue with Insurance Section

PERSON RESPONSIBLE FOR THIS ACCOUNT OTHER THAN ABOVE NAMED PATIENT

Responsible Party's Name_____ Birthdate_____ Sex ❒ M ❒ F

Street Address (If Dif. Than Above)_____ Phone _____
Street City Zip

DL# _____

Responsible Party's Employer_____ No. of yrs. Employed_____ Soc. Sec. No._____

Business Address_____ Phone _____

FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name_____Birthdate_____Soc. Sec. No. _____

Subscriber's Employer_____Business Address_____Insurance Co. _____

Group No. _____ Deductible ❒ Yes ❒ No Max. Benefit_____ Benefit Year_____

Patient's Relationship to Subscriber ❒ Self ❒ Spouse ❒ Dependent Have You Used Your Dental Insurance Previously? ❒ Yes ❒ No

Are You Covered Under More Than One Dental Plan? ❒ Yes ❒ No If Yes: Please Fill Out Next Section

SECONDARY INSURANCE

Subscriber's Name_____Birthdate_____Soc. Sec. No. _____

Insurance Co._____ Group No._____ Employer_____ Relationship to Patient _____

LIST MEDICATIONS CURRENTLY TAKING

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY

General Health (please check) ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Name and address of physician _____

_____

Last complete physical? _____

Are you taking any medication now? ❒ Yes ❒ No For what purpose? _____

Do You have or have you had any of the following? Please indicate with check mark (✓).

_____Any heart problems	_____Allergies to anesthetics	_____Hepatitis	_____Sinus problems
_____High blood pressure	_____Allergies to medicine	_____Herpes	_____Stroke
_____Low blood pressure	or drugs	_____Malignancies	_____Typhoid Fever
_____Circulatory problems	_____Allergies to_____	_____Measles	_____Tonsillitis
_____Nervous problems	_____Anemia	_____Mumps	_____Tuberculosis
_____Radiation treatments	_____Arthritis	_____Psychiatric care	_____Ulcer
_____Excessive bleeding	_____Asthma	_____Rheumatic Fever	_____Venereal Disease
_____AIDS	_____Diabetes	_____Scarlet Fever	_____Other

Blood Pressure: A_____/D_____/_____

Have you ever been treated (other than diagnostic) with x-ray? ..... ❒ Yes ❒ No

Are you allergic to : ❒ Penicillin ❒ Codeine ❒ Local-injected anesthetics ❒ Other medications_____

Are you subject to prolonged bleeding? ..... ❒ Yes ❒ No

Are you subject to fainting spells? ..... ❒ Yes ❒ No

(Women) Are you pregnant? .....❒ Yes ❒ No How long!_____

DENTAL HISTORY

Date of last dental visit_____ Dentist's Name_____ Phone_____ _

Did you have x-rays taken? ..... ❒ Yes ❒ No

Have you had all your teeth x-rayed in the past 3 years? ..... ❒ Yes ❒ No

Do you wear full or partial dentures? ..... ❒ Yes ❒ No (If Yes) How old are they:_____

Does any member of your family including your parents wear dentures ..... ❒ Yes ❒ No

Are you dissatisfied with the appearance of your teeth? ..... ❒ Yes ❒ No

Have you had orthodontic treatment ..... ❒ Yes ❒ No

Do you clench or grind your teeth during the day or night? ..... ❒ Yes ❒ No

Have you ever had pain in your jaw joint or your face (in and about your ears)? ..... ❒ Yes ❒ No

Does your jaw joint click_____ ❒ Yes ❒ No Do you have difficulty opening your mouth widely? ..... ❒ Yes ❒ No

Do you have an unpleasant odor, or bad taste in your mouth? ..... ❒ Yes ❒ No

Do your gums bleed when brushing? ❒ Yes ❒ No Have you had gum disease or pyorrhea? ..... ❒ Yes ❒ No

Is your mouth or teeth sensitive to.....Pressure ❒ Yes ❒ No Cold ❒ Yes ❒ No Hot ❒ Yes ❒ No

Does food catch between your teeth? ..... ❒ Yes ❒ No

Please add anything you feel is important for the doctor to know _____

_____

_____

Patient's Signature_____