REGISTRATION & TREATMENT

Date ___________________________

PATIENT INFORMATION

Name ____ SS#/ID# ____________________________________
Last First Middle

Address ____ Birth date ______/__ ____/________ Age _________

City ______________________________ State ______ Zip ______________ Sex ☐ Male ☐ Female

Home Phone (_____) ________________ Cell Phone (_____) ________________ Business Phone (_____) _______________

E-Mail Address ____

Whom may we thank for referring you? _______________________

In case of an emergency who should we notify? ________________________ Phone (_____) _______________

PRIMARY DENTAL INSURANCE

Person Responsible for Account ____
Last First Middle

Relationship to Patient ______________ Birth date ______/__ ____/________ SS#/ID# ____________________________________

Phone (_____) ________________

Subscriber employed by ___________________________ Phone (_____) ________________

Insurance Company ______________________________Group # _____________________ Subscriber # ____________________

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional insurance? ☐ Y ☐ N SS#/ID#_______________________________

Subscriber Name Relationship to Patient____ Birth date ____/____/________

Subscriber employed by____ Phone (_____) ________________

Insurance Company ______________________________Group # _____________________ Subscriber # ____________________

Please fill out reverse side

MEDICAL HISTORY & INFORMATION

Reason for Today's Visit ___________________________________ **Date of last dental care** ____________________________________

Former Dentist ____ **Date of last dental X-Ray** ___________________________________

Please check if you have problems with the following:

□ Bad breath □ Grinding teeth □ Sensitivity to hot or cold □ Bleeding Gums □ Sensitivity to sweets □ Loose teeth / broken fillings

□ Clicking / popping jaw □ Sensitivity when biting □ Food collection b/w teeth □ Sores or growths in your mouth

CONDITIONS

- □ Abnormal Bleeding
- □ Alcohol Abuse
- □ Allergies (environmental)
- □ Anemia
- □ Angina Pectoris
- □ Arthritis
- □ Artificial Heart Valve
- □ Asthma
- □ Blood Transfusion
- □ Cancer
- □ Chemotherapy
- □ Colitis
- □ Congenital Heart Defect
- □ Depression
- □ Diabetes
- □ Difficulty Breathing
- □ Drug Abuse
- □ Emphysema
- □ Epilepsy
- □ Facial Surgery
- □ Fainting Spells
- □ Fever Blisters
- □ Frequent Headaches
- □ Glaucoma
- □ HIV+ / Aids
- □ Heart Attack
- □ Heart Murmur
- □ Heart Surgery
- □ Hemophilia
- □ Hepatitis A
- □ Hepatitis B
- □ Hepatitis C
- □ High Blood Pressure
- □ Joint Replacement
- □ Kidney Problems
- □ Liver Disease
- □ Low Blood Pressure
- □ Mitral Valve Prolapse
- □ Pacemaker
- □ Psychiatric Problems
- □ Radiation Therapy
- □ Rheumatic Fever
- □ Seizures
- □ Sexually Transmitted Disease
- □ Shingles
- □ Sickle Cell Disease
- □ Sinus Problems
- □ Stroke
- □ Thyroid Problems
- □ Tuberculosis
- □ Ulcers
- □ Other Conditions (list); _________________ _________________ _________________

ALLERGIES

- □ Aspirin
- □ Codeine
- □ Dental Anesthetics
- □ Erythromycin
- □ Latex
- □ Metals
- □ Penicillin
- □ Sulfa
- □ Tetracycline
- □ Other: _______________

Y/ N

□ □ Do you use tobacco?

Y/ N IF FEMALE

□ □ Are you taking Birth Control Pills?
□ □ Are you pregnant?
If yes, # of weeks:______
□ □ Are you nursing?

SMILE ANALYSIS

Y/ N

□ □ Are you interested in Invisalign?

□ □ Would you like whiter teeth?

□ □ Are you interested in a cosmetic consultation?

□ □ Are you interested in implants?

SLEEP ANALYSIS

□ □ Do you snore loudly?

□ □ Do you often feel tired?

□ □ Has anyone ever observed you stop breathing or gasping while asleep?

□ □ Do you have or are you being treated for high blood pressure?

Name of General Physician: ____

Please list any medications you are currently taking: ____

____

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. Payment for all treatment and services rendered are my responsibility.

____ _______________________

PATIENT'S SIGNATURE **DATE**

If patient is under 18 years old or requires a guardian:

____ _______________________

PARENT/ GUARDIAN SIGNATURE **DATE**

____

Print Patient Name I Guardian Name