# 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**