PATIENT REGISTRATION

DATE_____

ACCOUNT_____-_____

Patient's Name_____/_____ **Sex M F**
Last First Middle Initial Preferred Name/ Nickname

Title: Mr. Mrs. Ms. Dr. Marital Status : Single Married Divorced Widowed Separated Birthdate_____/_____/_____

Patient's Address _____**City**_____ **State**_____ **Zip**_____ **Cell**_____

Home Phone_____ **Patients SS #**_____-_____-_____ **Email**_____@_____

Patients Employer _____ **Phone**_____ **Patients Occupation**_____

Name of Spouse_____ **Spouse SS #** _____-_____-_____ **Birthdate**_____/_____/_____
Last (if Different) First

Spouse's Employer_____ **Phone** _____ **Occupation** _____

Who is responsible for this account? Self Spouse Mother Father Other _____ **Phone** _____

Person to Contact in Emergency_____**Phone**_____**Relationship**_____

REFERRED TO OFFICE BY_____

FOR PATIENTS COVERED BY INSURANCE

Date Eligible_____

Subscriber's Name_____ **Birthday**_____/_____/_____ **SS #** _____-_____-_____

Subscriber's Employer_____ **Dental Insurance** _____**Phone**_____

Group #_____**Employee/Alt ID No.**_____ **Patient's relationship to Subscriber Self Spouse Dependent**

SECONDARY INSURANCE INFORMATION

Date Eligible_____

Subscriber's Name _____ **Birthday**_____/_____/_____ **SS#** _____-_____-_____

Subscriber's Employer_____ **Dental Insurance**_____**Phone**_____

Group #_____ **Employee/Alt ID No.** _____**Patient's relationship to Subscriber Self Spouse Dependent**

Dental Information:

Do your gums bleed when you brush or floss	Y	N	Do you have dry mouth problems	Y	N
Have you had periodontal (gum) treatments or Surgery	Y	N	Surgery/perio treatment Date _____		
Are your teeth sensitive to cold, hot, sweets, or pressure	Y	N	Have you had a serious injury to your head or mouth	Y	N
Have you ever had orthodontic (braces)	Y	N	Do you have any problems or allergies with anesthetic	Y	N
Do you have clicking, popping, discomfort in the jaw	Y	N	Do you brux (grind) or clench your teeth	Y	N
Do you snore or have sleep apnea	Y	N	Do you wear dentures or partials	Y	N
If yes, do you wear a sleep appliance	Y	N	What year were they made _____		

Name of previous dentist/last visit _____**Date**_____ **Phone:** _____

How do you feel about your smile? Would you like to change anything about the appearance of your teeth (whitening, braces, fill in missing spaces) _____

Do you have any anxiety about dental treatment….Explain:_____

Medical Information:

1. **Has your physician ever advised you to take antibiotics prior to dental treatment Y N**
   Have you had a total joint replacement or any organ transplants Date_____ Y N
   Do you have a prosthetic (artificial) heart valve Y N
   Do you have congenital heart disease (from birth) Y N
2. **Are you currently or have you ever taken any oral or IV medications (bisphosphonates) for osteoporosis or bone related cancer Y N**
   If yes, when was your last treatment _____ Oral or IV _____
3. **List any and all medications, vitamins, or herbs you are currently taking:_____**

_____ ☐ SEE LIST IN CHART

Do you take aspirin or blood thinning medications (Plavix, Coumadin, Warfarin…) Y N
Has there been any change in your health in the past year Y N If yes, explain: _____
Please list any prior surgeries you have had and the year: _____
Date of last physical: _____Physician Name: _____ Phone Number: _____
Do you smoke/chew tobacco Y N how many packs a day _____
Do you have any history of addiction to alcohol or drugs Y N Do you drink alcohol Daily Weekly Monthly

4. **(Women) Are you taking birth control pills or undergoing hormone replacement therapy Y N**
   If trying to get pregnant or pregnant, how many weeks _____ Nursing Y N

5. **Allergies: Are you allergic to or have you had a reaction to any of the following:**

Latex Allergy	**Y N**	**Aspirin**	**Y N**	**Penicillin**	**Y N**	**Iodine**	**Y N**
Codeine or other narcotics	**Y N**	**Metals**	**Y N**	**Sulfa**	**Y N**	**Sedatives**	**Y N**

Other antibiotics/drugs _____

Cardiovascular (Heart) Disease.....Y N	**Angina.....Y N**	**Heart Attack Date _____Y N**	**Stroke Date_____ Y N**
Congestive Heart Failure.....Y N	**Damaged Heart Valves .Y N**	**Heart Murmur.....Y N**	**High/Low Blood Pressure....Y N**
Mitral Valve Prolapse.....Y N	**Pacemaker.....Y N**	**Rheumatic Fever..... Y N**	**Anemia or Blood Disorder...Y N**
Abnormal Bleeding.....Y N	**Blood Transfusion..... Y N**	**Autoimmune Disease.....Y N**	**Cancer Year_____ Y N**
AIDS/HIV.....Y N	**Asthma.....Y N**	**Hepatitis or Liver Disease.....Y N**	**Radiation/Chemo.....Y N**
Emphysema.....Y N	**Arthritis.....Y N**	**Sinus Trouble /Hay Fever.....Y N**	**Tuberculosis.....Y N**
COPD.....Y N	**Headaches/Migraines....Y N**	**Ulcers.....Y N**	**Thyroid Problems.....Y N**
Osteoporosis.....Y N	**Hypoglycemia.....Y N**	**Diabetes.....Y N**	**Eating Disorder.....Y N**
Glaucoma.....Y N	**Epilepsy or Seizures.....Y N**	**Neurological Disorders.....Y N**	**Recurrent Infections.....Y N**
Physical,Mental or Emotional.....Y N	**Psychiatric Care.....Y N**	**Kidney Problems.....Y N**	**Herpetic or HPV Infections..Y N**
Disability or Disorder	**Serious Accident.....Y N**	**Reflux.....Y N**	**Gastrointestinal Disease.....Y N**
Severe or Rapid weight loss.....Y N			

Do you have any diseases or conditions not mentioned above that we should know about? Y N

Explain: _____

Signature of Dentist: _____ Date: _____

I certify that I have read and understand the above and that the information given on this form is accurate. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I authorize release of any information to process my insurance claim. I also authorize payment directly to the dentist of the insurance benefits otherwise payable to me. A copy of this signature is as valid as the original.

I have received notice of privacy practices

Signature of Patient/Legal Guardian:_____ Date: _____