

PATIENT REGISTRATION

Date: ____/____/____

Answers to the following questions are for our records only. They will be considered confidential and will become part of your permanent dental record.

Patient's Name: _____ Male/Female

Social Security Number: ____/____/____ Date of Birth: ____/____/____

How would you like to be addressed (Dr., Nickname, etc.) _____

Mailing Address _____ Home Phone# _____

City _____ State _____ Zip Code _____ Cell# _____

Physical Address _____

Employed by _____ Present Position _____

Work Address _____ Work Phone# _____

Spouses Name _____ Date of Birth: ____/____/____

Spouse Employed by _____ Present Position _____

Who will pay this account _____ Relation _____

Whom may we thank for the referral _____

****As a courtesy to our patients, an attempt will be made to confirm your appointment. A \$60 PENALTY FEE will be charged for each failed appointment (whether confirmed or not) without 24 hours notice.****

***PLEASE INITIAL _____**

Dental Insurance Coverage

Dental Insurance 2nd Coverage

Name of Insurance Company _____

Name of Insurance Company _____

Subscriber _____

Subscriber _____

Subscriber Policy# _____

Subscriber Policy# _____

Group# _____

Group# _____

Subscriber Date of Birth ____/____/____

Subscriber Date of Birth ____/____/____

Patient's Name _____

Date of Birth ____/____/____ Height _____ Weight _____

Physician's Name _____ Physicians Phone # _____

Date of last visit to physician _____ Reason for last visit to physician _____

In case of emergency contact _____ Phone# _____

Please circle Yes or No for the following questions. If you are unsure of question please leave blank.

- | | | |
|---|-----|----|
| 1. Are you currently being treated by a physician? | Yes | No |
| 2. Are you taking any medications now? | Yes | No |
| 2a. Please list current medications | | |
| 3. Are you allergic or sensitive to any medications? | Yes | No |
| 4. Has there been any change with your health within the last year? | Yes | No |
| 5. Have you lost weight without dieting in recent months? | Yes | No |
| 6. Do you have any artificial joints/prosthesis? | Yes | No |
| 7. Have you ever been seriously ill or hospitalized? | Yes | No |
| 8. Have you ever had surgery? | Yes | No |
| 9. Have you ever been treated for a growth or tumor in any part of your body? | Yes | No |
| 10. Do you bleed for a long time when you cut yourself? | Yes | No |
| 11. Do you take aspirin daily? | Yes | No |
| 12. Have you ever been told by a physician that you have a heart murmur? | Yes | No |
| 13. Are you on blood thinners? | Yes | No |
| 14. Have you ever had any of the following? | | |
| Jaundice..... | Yes | No |
| Glaucoma..... | Yes | No |
| Rheumatic Fever..... | Yes | No |
| Hepatitis..... | Yes | No |
| Diabetes..... | Yes | No |
| Asthma..... | Yes | No |
| Venereal Disease..... | Yes | No |
| Heart Problems..... | Yes | No |
| High Blood Pressure..... | Yes | No |
| Chest Pains..... | Yes | No |
| Thyroid Problems..... | Yes | No |
| Pacemaker..... | Yes | No |
| Tuberculosis..... | Yes | No |
| Anemia..... | Yes | No |
| Hives or Skin Rash..... | Yes | No |
| Ulcers..... | Yes | No |
| Epilepsy/Convulsions..... | Yes | No |
| Stroke..... | Yes | No |
| Blood Disorder..... | Yes | No |
| Sinus Problems..... | Yes | No |
| Kidney Problems..... | Yes | No |
| Radiation Therapy..... | Yes | No |
| Drug Dependency (Alcohol, etc)... | Yes | No |
| Psychiatric Treatment..... | Yes | No |
| 15. Have you ever had any unusual reactions to dental anesthetic? | Yes | No |
| 16. Do you often feel exhausted or fatigued? | Yes | No |
| 17. Do you have a tendency to faint? | Yes | No |
| 18. Do you have frequent headaches? | Yes | No |
| 19. Do you smoke or use smokeless tobacco? | Yes | No |
| 20. Are you at a high risk for AIDS? | Yes | No |
| 21. Any other condition or disease not mentioned? | Yes | No |
| 22. Would you like to speak to the doctor privately about any problem? | Yes | No |
| 23. Women: | | |
| Are you pregnant or suspect that you may be at this time?..... | Yes | No |
| Are you nursing?..... | Yes | No |
| Are you in or passed through menopause?..... | Yes | No |

To the best of my knowledge, all of the preceding information is complete and my answers are true and correct. If I ever have any change in my health, or if my medication changes, I will inform the dentist at the next appointment.

Signature _____ Date ____/____/____ Reviewed by _____

HEALTH QUESTIONNAIRE

Patient's Name _____ On a holistic scale of 1-10 how do you rate yourself? _____

1. Why are you seeking dental treatment? _____

2. How long since you have been to a dentist? _____

3. What was done then? _____

4. Name of last dentist? _____

5. When were your last x-rays taken? _____ When was your last cleaning? _____

6. How often did you visit a dentist before your last visit? _____

7. How often do you brush your teeth? _____ How often do you floss? _____

For the following questions please circle Yes or No

- | | | |
|---|-----|----|
| 8. Do you use anything else to clean your teeth and gums? | Yes | No |
| 9. Are you satisfied with appearance of your teeth? | Yes | No |
| 10. Have you ever had your teeth straightened? | Yes | No |
| 11. Any complications with extractions? | Yes | No |
| 12. Are any teeth sensitive to hot? | Yes | No |
| 13. Are any teeth sensitive to cold? | Yes | No |
| 14. Are any teeth sensitive to sweets? | Yes | No |
| 15. Are any teeth sensitive to chewing? | Yes | No |
| 16. Do you have bleeding gums? | Yes | No |
| 17. Does food wedge between your teeth? | Yes | No |
| 18. Do you grind your teeth? | Yes | No |
| 19. Have you ever had gum treatments? | Yes | No |
| 20. Do you feel you may have bad breath? | Yes | No |
| 21. Have you ever noticed an unpleasant taste in your mouth? | Yes | No |
| 22. Does your jaw frequently pop or click? | Yes | No |
| 23. Do you have any nasal obstruction? | Yes | No |
| 24. Have you had sores in your mouth? | Yes | No |
| 25. Do you have any difficulty opening your mouth? | Yes | No |
| 26. Do you have any difficult chewing? | Yes | No |
| 27. Are you aware of any swelling or lump under your chin or along your neck? | Yes | No |
| 28. Are you aware of any swelling or lump in your mouth? | Yes | No |
| 29. Do you now have or have had any habits of biting/sucking on any object or part of your mouth? | Yes | No |
| 30. Are you happy with your previous dental work? | Yes | No |
| 31. Were there any complications or problems with your last dental treatment? | Yes | No |

Signature _____ Date ____ / ____ / ____ Reviewed by _____

Doctor's Notes:

DENTAL HISTORY