PATIENT REGISTRATION *TODAY'S DATE* _____

First Name_____ MI____ Last Name_____

Nickname_____ DOB:_____ Gender: □Male □Female □Other

Mailing Address _____

City/State/Zip_____ e-mail_____

Please check your telephone preference

□Home Phone_____ □Cell Phone_____ □Work Phone_____

HIPAA Contact_____ Phone Number_____ Relationship to patient_____

Emergency Contact_____ Phone Number_____ Relationship to patient_____

DENTAL INSURANCE – Please provide copy of insurance card(s)

Primary Dental Insurance:

Insurance Company_____ Employer_____

Subscriber's Name_____ Subscriber's Birth Date_____

Subscriber's ID# (or SSN)_____ Group/Plan#_____

Relationship to Patient: □Self □Spouse □Parent □Other (Please specify)_____

Secondary Dental Insurance

Insurance Company_____ Employer_____

Subscriber's Name_____ Subscriber's Birth Date_____

Subscriber's ID# (or SSN)_____ Group/Plan#_____

Relationship to Patient: □Self □Spouse □Parent □Other (Please specify)_____

How were you referred to our office?_____

DENTAL HISTORY

Previous Dentist_____ Phone_____

Date of your last dental visit_____ Did you have a dental cleaning? □YES □NO

Frequency of dental visits_____ Were x-rays taken? □YES □NO

Would you like our office to request any current x-rays from your previous dentist? □YES □NO

How often do you brush?_____ How often do you Floss?_____

Have you ever experienced any complications or problems with previous dental treatment? □YES □NO

If yes, please explain:_____

Do your gums bleed or hurt? □YES □NO

Do you have any sensitive teeth? □YES □NO

Do you have removed or lost teeth? □YES □NO

Have you ever had gum surgery? □YES □NO

Have you had orthodontic treatment? □YES □NO

Do you clench or grind your teeth? □YES □NO

Any soreness or pain in your jaw? □YES □NO

Does your jaw lock or pop? □YES □NO

Do you fear dental treatment? □YES □NO

Do you wear dentures or dental appliances? □YES □NO

Have you ever had a reaction to dental anesthetic? □YES □NO

If Yes, please describe:_____

_____

_____

MEDICAL HISTORY

Name of Physician_____ Phone_____

Heart Problems _____
☐ Chest pains ☐ Shortness of breath
☐ Do you take Nitroglycerine tablets
☐ High Blood Pressure ☐ Low Blood Pressure
☐ Taking heart medication ☐ Heart murmur
☐ Rheumatic Fever ☐ Pacemaker
☐ Heart Valve Problem/Artificial Heart Valve
Are you required to take pre-medication (prophylactic antibiotics)? □YES □NO

Blood Problems _____
☐ Easy bruising ☐ Abnormal bleeding
☐ Frequent nose bleeds ☐ Leukemia
☐ Blood disease (anemia) ☐ Blood transfusion

Allergy Problems _____
☐ Hay fever / Allergies ☐ Sinus problems
☐ Taking allergy medication(s) ☐ Skin rashes
☐ Asthma / Inhaler Usage □YES □NO

Intestinal Problems _____
☐ Ulcers ☐ Gastric Reflux
☐ Weight gain or loss ☐ Special diet
☐ Constipation or Diarrhea
☐ Kidney or bladder problems

Other Systems _____
☐ Fainting spells, seizures, epilepsy, or other neurological disease
☐ History of head injury ☐ Stroke(s)
☐ Frequent or severe headaches
☐ Thyroid problems ☐ Glaucoma
☐ Persistent cough or swollen glands
☐ Cancer/Tumor
Please describe:_____
☐ Diabetes
Please describe:_____
☐ Family history of diabetes
☐ Thirsty or dry mouth ☐ Frequent urination
☐ Tuberculosis or other respiratory disease
☐ Hepatitis: A B C, Jaundice, or Liver Disease
☐ Herpes or other STD ☐ HIV positive / AIDS
☐ History of alcohol or drug abuse

For Women
Do you take contraceptives/hormones? □YES □NO
Are you pregnant? □YES □NO
Are you nursing? □YES □NO
Have you reached menopause? □YES □NO

Bone or Joint Problems _____
☐ Arthritis ☐ Back or neck pain
☐ Osteoporosis
Have you ever taken Bisphosphonates? (e.g. Fosamax, Boniva…) □YES □NO

Do you have artificial joints? (e.g. hip, knee, pins or implants?) □YES □NO
Date placed:_____
If yes, are you required to use prophylactic antibiotics (pre-medication)? □YES □NO

Do you wear contact lenses? □YES □NO
Do you use tobacco products? □YES □NO
If so, how much?_____
Do you use cannabis products? □YES □NO
If so, how much?_____
Do you drink alcohol? □YES □NO
If so, how much? _____

Do you have any disease, condition, or problem not listed previously?
If so, please describe: _____
_____
_____

Please list and/or provide a list of any medications you have taken or are currently taking during the past 12 months:
_____
_____

Drug Allergies/Reactions
Have you reacted adversely or are you allergic to any of the following? (Please circle specifics)
☐ Dental anesthetic
☐ Latex or Rubber Dam
☐ Antibiotics: eg: Penicillin, Augmentin, Sulfa
☐ Barbiturates, Sedatives, Sleeping pills
☐ Aspirin, Acetaminophen, Ibuprofen
☐ Reaction to Metals
☐ Codeine, Demerol, other Narcotics

Please list any other allergies:_____
_____
_____
_____
_____

→ **Patient Signature**_____ **Dentist Initial**_____