

## Patient Registration

Your Cooperation in Completing This Questionnaire is Essential To Providing you with the Highest Standard of Dental Care. All Information is Confidential.  
Please Print and Answer all Questions.

Date: \_\_\_\_\_

Is there a dental problem you would like treated immediately?

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone (      ) \_\_\_\_\_ Work Phone (      ) \_\_\_\_\_

Cell Phone (      ) \_\_\_\_\_ Pager (      ) \_\_\_\_\_

Employer \_\_\_\_\_ How Long \_\_\_\_\_ Position \_\_\_\_\_

SS # \_\_\_\_\_ Spouse SS # \_\_\_\_\_

Spouse Employer \_\_\_\_\_ How Long \_\_\_\_\_ Position \_\_\_\_\_

If Student School \_\_\_\_\_ Drivers Lic.# \_\_\_\_\_

Referred By \_\_\_\_\_

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I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. I understand it is my responsibility to verify insurance coverage with the insurance company prior to my appointment. In the event your account goes to collections a 50% fee will be added to your balance.

We do not participate with any HMO or PDO plans or networks.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent or Guardian if Minor)

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### Payment is due in full at time of treatment unless prior arrangements have been made

#### PRIMARY DENTAL INSURANCE

#### SECONDARY DENTAL INSURANCE

Insured's Name \_\_\_\_\_ Insured's Name \_\_\_\_\_

S.S.N. \_\_\_\_\_ D.O.B. \_\_\_\_\_ S.S.N. \_\_\_\_\_ D.O.B. \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Group# \_\_\_\_\_ Group# \_\_\_\_\_

# HEALTH HISTORY

Please answer each question. Check yes or no.

- |  | YES | NO |
|--|-----|----|
| 1. Are you in good health now? .....   | 0   | 0  |
| 2. Are you now under the care of a physician? .....  | 0   | 0  |
| If so, what is the condition being treated? _____  |     |    |
| 3. Have you ever been hospitalized or had a serious illness? .....   | 0   | 0  |
| 4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? ..... | 0   | 0  |
| 5. (Women) Are you pregnant? If so, give due date _____  | 0   | 0  |
| 6. Do you use tobacco in any form? If yes, how much? _____   | 0   | 0  |
| 7. Do you use alcoholic beverages (more than 2 drinks per day)? .....  | 0   | 0  |
| 8. Do you have or have you ever had any of the following?  |     |    |
| 9. Are you ALLERGIC or have you ever experienced any reaction to the following?  |     |    |

	YES	NO
Penicillin	0	0
Local anesthetics (e.g. novocaine)	0	0
Barbiturates / sedatives / sleeping pills	0	0
Latex	0	0
Other antibiotics	0	0

### GENERAL

Wake with headaches	0	0
Tire easily, weakness	0	0
Night sweats	0	0
Persistent fever	0	0
Transplants	0	0

### SKIN

Eruptions (rash) hives	0	0
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### EYES

Glaucoma	0	0
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### EARS

Hearing aid	0	0
Ringing in ears	0	0

### NOSE

Frequent nose bleeds	0	0
Sinus problems	0	0

### THROAT

Frequent soreness	0	0
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### NERVOUS SYSTEM

Seizures	0	0
Frequent headaches	0	0
Convulsions / epilepsy	0	0
Numbness / tingling	0	0
Dizziness / fainting	0	0
Psychiatric treatment	0	0

### RESPIRATORY

Tuberculosis	0	0
Emphysema	0	0
Asthma / hay fever	0	0
Persistent cough	0	0
Difficulty breathing while lying down	0	0

### ENDOCRINE

Diabetes	0	0
Thyroid condition / goiter	0	0
Other _____		

	YES	NO
Aspirin	0	0
Codeine	0	0
Sulfa drugs	0	0
Other allergies	0	0

### IMPLANTS

(may require antibiotics prior to dental treatment)

Dental	0	0
Hip or knee	0	0
Breast	0	0
Other _____		

### HEART / BLOOD VESSELS

Rheumatic Fever	0	0
Heart murmur	0	0
Chest Pain / Angina	0	0
Heart Attack / Disease	0	0
Shortness of breath	0	0
High or low blood pressure	0	0
Congenital heart disease	0	0
Artificial heart valve	0	0
Pacemaker	0	0
Heart surgery	0	0
Other _____		

### BONE / MUSCLES

Arthritis / rheumatism	0	0
Artificial joints or pins	0	0

### Digestive System

Liver disease	0	0
Hepatitis	0	0
Ulcers	0	0

### URINARY

Kidney disorders	0	0
Venereal disease	0	0

### BLOOD

Bleeding disorders	0	0
Bruise easily	0	0
Anemia	0	0

### OTHER

Blood transfusion	0	0
Reaction to local anesthetic	0	0
Drug addiction	0	0
Radiation therapy	0	0
Tumors or growth	0	0
Cancer	0	0
AIDS	0	0
Chemotherapy	0	0
H.I.V. positive	0	0

10. Are you taking or have you recently taken any of the following?

	YES	NO		YES	NO
Antibiotics/sulfa drugs	<input type="radio"/>	<input type="radio"/>	Fosomax	<input type="radio"/>	<input type="radio"/>
Blood thinners	<input type="radio"/>	<input type="radio"/>	Tranquilizers	<input type="radio"/>	<input type="radio"/>
Blood pressure medications	<input type="radio"/>	<input type="radio"/>	Insulin/other diabetes drugs	<input type="radio"/>	<input type="radio"/>
Thyroid medicine	<input type="radio"/>	<input type="radio"/>	Recreational drugs	<input type="radio"/>	<input type="radio"/>
Cortisone/steroids	<input type="radio"/>	<input type="radio"/>	Digitals / other		
Antihistamines / allergy drugs / cold remedies	<input type="radio"/>	<input type="radio"/>	heart medications	<input type="radio"/>	<input type="radio"/>
Birth control pills	<input type="radio"/>	<input type="radio"/>	Nitroglycerin	<input type="radio"/>	<input type="radio"/>
Diet drug Redux, Pondimin (Fen-Fen)	<input type="radio"/>	<input type="radio"/>	Aspirin	<input type="radio"/>	<input type="radio"/>
			Other medications	<input type="radio"/>	<input type="radio"/>

If yes to any of the above, list name of medication and dosage below:

- a) \_\_\_\_\_  
 b) \_\_\_\_\_  
 c) \_\_\_\_\_

**Doctor's Name and Address:** \_\_\_\_\_

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? \_\_\_\_\_

12. Have you ever had any serious trouble associated with previous dental treatments? \_\_\_\_\_

13. Does dental treatments make you nervous? No  Slightly  Moderately  Extremely

14. Date of last dental visit \_\_\_\_\_

15. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? \_\_\_\_\_

16. Do you have or have you ever had any of the following?

<b>Mouth</b>	Yes	No	<b>Teeth</b>	Yes	No
Bleeding, sore gums	<input type="radio"/>	<input type="radio"/>	Loose teeth	<input type="radio"/>	<input type="radio"/>
Unpleasant taste / bad breath	<input type="radio"/>	<input type="radio"/>	Sensitive to hot	<input type="radio"/>	<input type="radio"/>
Burning tongue / lips	<input type="radio"/>	<input type="radio"/>	Sensitive to cold	<input type="radio"/>	<input type="radio"/>
Frequent blisters, lips / mouth	<input type="radio"/>	<input type="radio"/>	Sensitive to sweets	<input type="radio"/>	<input type="radio"/>
Swelling / lumps in mouth	<input type="radio"/>	<input type="radio"/>	Sensitive to biting	<input type="radio"/>	<input type="radio"/>
Ortho treatment (braces)	<input type="radio"/>	<input type="radio"/>	Food Impaction	<input type="radio"/>	<input type="radio"/>
Biting cheeks / lips	<input type="radio"/>	<input type="radio"/>	Clenching / grinding	<input type="radio"/>	<input type="radio"/>
Clicking / popping jaw	<input type="radio"/>	<input type="radio"/>	Shifting of teeth	<input type="radio"/>	<input type="radio"/>
Difficulty opening or closing jaw	<input type="radio"/>	<input type="radio"/>	Change in bite	<input type="radio"/>	<input type="radio"/>

<b>Oral Hygiene</b>		
Do you use the following?		
Brush	<input type="radio"/>	How often do you floss? _____
Dental floss	<input type="radio"/>	How often do you brush? _____
Fluoride rinse	<input type="radio"/>	
Other _____		Brush is: Soft <input type="radio"/> Medium <input type="radio"/> Hard <input type="radio"/>

**GENERAL RELEASE**

I, the undersigned, certify that I have provided an accurate and complete personal and medical dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical dental history. Should there be any change in my health status in the futures, I will advise this dental office. I authorize the dentist to perform diagnosis procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and may dependents is mine, and I assume responsibility for fees associated with these services.

**X** \_\_\_\_\_  
 (signature) Patient  Parent  Guardian  \_\_\_\_\_  
 (print name of guardian)

Reviewed by Treating Dentist: \_\_\_\_\_ Date: \_\_\_\_\_

**ANNUAL MEDICAL UPDATES**

Have you changed your Family Physician? Yes  No  New Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you under the care of a Medical Specialist? Yes  No  Specialist: \_\_\_\_\_ Type: \_\_\_\_\_

Are there any changes to your Health History? Yes  No  Please specify: \_\_\_\_\_

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List medications (Prescriptions or Non-Prescription Drugs) currently used: 1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**X** \_\_\_\_\_ Date: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

(signature) Patient  Parent  Guardian  Doctor's Initials \_\_\_\_\_ Date: \_\_\_\_\_

Have you changed your Family Physician? Yes  No  New Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you under the care of a Medical Specialist? Yes  No  Specialist: \_\_\_\_\_ Type: \_\_\_\_\_

Are there any changes to your Health History? Yes  No  Please specify: \_\_\_\_\_

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List medications (Prescriptions or Non-Prescription Drugs) currently used: 1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**X** \_\_\_\_\_ Date: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

(signature) Patient  Parent  Guardian  Doctor's Initials \_\_\_\_\_ Date: \_\_\_\_\_

Have you changed your Family Physician? Yes  No  New Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you under the care of a Medical Specialist? Yes  No  Specialist: \_\_\_\_\_ Type: \_\_\_\_\_

Are there any changes to your Health History? Yes  No  Please specify: \_\_\_\_\_

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List medications (Prescriptions or Non-Prescription Drugs) currently used: 1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**X** \_\_\_\_\_ Date: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

(signature) Patient  Parent  Guardian  Doctor's Initials \_\_\_\_\_ Date: \_\_\_\_\_

Have you changed your Family Physician? Yes  No  New Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you under the care of a Medical Specialist? Yes  No  Specialist: \_\_\_\_\_ Type: \_\_\_\_\_

Are there any changes to your Health History? Yes  No  Please specify: \_\_\_\_\_

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List medications (Prescriptions or Non-Prescription Drugs) currently used: 1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**X** \_\_\_\_\_ Date: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

(signature) Patient  Parent  Guardian  Doctor's Initials \_\_\_\_\_ Date: \_\_\_\_\_