Patient Registration

Legal Name* Last	First	Middle Initial	
Legal Sex (please circle one) *	Female	Male	**Preferred Name:**
Date of Birth *Month Day Year* / /	**Social Security #**	**State ID # or License #** (i f applicable)	

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone ( ) **Ok to leave voicemail?** ☐ Yes ☐ No	**Cell Phone** ( ) **Ok to leave voicemail?** ☐ Yes ☐ No	**Work Phone** ( ) **Ok to leave voicemail?** ☐ Yes ☐ No	**Best number to use:** ☐ Home ☐ Cell ☐ Work
Address	City	State	ZIP
Email address:			
Occupation	Employer/School Name	Are you covered under school or employer's insurance? ☐ Yes ☐ No	
Emergency Contact's Name	Phone Number	Relationship to you	

Dental Insurance Information (please present your insurance card(s) so a copy of the front and back can be taken)

Primary Dental Insurance Carrier:_________________________

Subscriber ID:____

Group Number: ____ _

Subscriber Name:____ Subscriber Date of Birth:________________

Subscriber Relationship to Patient:_____________________________

**If you have secondary dental insurance, please list below.*

____

Secondary Dental Insurance Carrier:____________________

Subscriber ID:____

Group Number:____

Subscriber Name:____ Subscriber Date of Birth:________________

Subscriber Relationship to Patient:_____________________________

Referral Source:

- ☐ Friend or Family Member: ____
- ☐ Insurance Carrier: ____
- ☐ Internet (please list search engine used): ____
- ☐ Social Media Platform (please specify):____
- ☐ Other: ____

Patient Signature:____ Date:_________________

MEDICAL DENTAL HISTORY FORM

Patient Name:____ **Patient DOB:**_________________________

Primary Care Physician:____

Pre-Med required (circle one)? Yes No

If yes, reason:______________________________Medication Type:_________________Dosage: ________

Allergies to: Latex?_______Sulfa? _______ Codeine? ______ Penicillin? ______ Other(s): _______

Current Medications: (prescription, over the counter, and herbal) *please attach additional sheet if needed

Medication	Dosage	Frequency

PAST AND CURRENT MEDICAL CONDITIONS (mark all that apply)

	Yes
8 Under physician's care?	
Details:	
9 Hospitalization/operation(s) in last 5 years?	
Details:	
10 Head/neck/mouth injuries?	
11 Women: pregnant?	
12 Women: nursing?	
13 Women: oral contraceptives?	
14 Heart trouble/disease?	
15 Rheumatic fever?	
16 Past use of Fenphen?	
17 Heart murmur?	
18 Mitral valve prolapse?	
19 Heart surgery?	
20 Artificial heart valves?	
21 Pacemaker?	
22 Indwelling defibrillator?	
23 Artificial joints?	
24 Historyof Organ Transplant?	
25 High blood pressure? BP: /	
26 Stroke?	
27 Bleeding problem?	
28 Hemophilia?	
29 Anemia?	
30 Leukemia?	
31 Lung disease?	
32 Emphysema?	
33 Shortness of Breath?	

	Yes
34 Asthma?	
35 Sleep Apnea?	
36 Tuberculosis?	
37 Sinus trouble?	
38 Cancer?	
39 Radiation Treatment to Head/Neck?	
40 Chemotherapy?	
41 Kidney Disease?	
42 Dialysis?	
43 Eating Disorder?	
44 Stomach: reflux? ulcer?	
45 Immunological disease?	
46 Sjogrens Disease?	
47 Fibromyalgia?	
48 Other autoimmune disease (lupus, pemphilus)?	
49 Arthritis or other joint disorders?	
50 Diabetes? Type: Controlled? Y N	
51 Headaches?	
52 Depression: Diagnosed?	
53 Other Psychiatric Disorders?	
54 Neurologic Disease?	
55 Convulsions?	
56 Epilepsy/seizures?	
57 Cerebral Palsy?	
58 Fainting/dizziness?	
59 Venereal disease?	
60 AIDS/HIV positive?	
61 Alcohol or chemical dependency?	
62 Hepatitis?	
63 Thyroid disease?	
64 Glaucoma?	

TOBACCO

	Yes
65 Tobacco user? Type: Amount: Number of years:	
66 How soon after wake up do you use tobacco? <30 minutes >30 minutes	
67 Previous attempts to quit? Number of attempts: Longer period of success: Methods used:	
68 Are you interested in quitting tobacco?	
69 Former tobacco user? Type: Amount: Year quit:	

DENTAL INFORMATION:

70 Previous dentist:	
71 Last dental visit:	
72 Last dental cleaning:	
73 Frequency of dental exams:	
74 What made you decide to make this dentist appointment?	
75 Frequency of brushing:	
76 Frequency of flossing:	
77 What are some typical foods you eat between meals?	
78 What types of beverages do you typically drink between meals?	
79 How often do you chew or suck on hard candy, cough drops or mints?	
80 Do you use fluoridated toothpaste?	
81 Primarysource of drinking water? (circle) City water filtered City waterunfiltered Bottled water Well water	

PAST DENTAL TREATMENT:

	Yes
82 One or more fillings in the last three years?	
83 Family history of extensive decay?	
84 If Child, mother's history of decay?	
85 Treatment for periodontal (gum) disease?	
86 Family history of periodontal disease?	
87 Have you had orthodontics (braces)?	
88 Have you had oral surgery?	
89 Have you had any dental implants placed?	
90 Treatment for temporomandibular disorders?	
91 Do you wear a denture(s) or partialdenture(s)?	

DO YOU HAVE CONSISTENT PROBLEMS WITH:

92 Dry mouth/excessive thirst?	
93 Sensitive teeth? Hot Cold Pressure Sweets	
94 Mouth odors/bad taste?	
95 Cold sores/blisters/oral lesions?	
96 Are you aware ofany swelling or lumps?	
97 Sore, bleeding gums?	
98 Loose teeth?	
99 Difficulty chewing?	
100 Food catches between teeth?	
101 Teeth/fillingbreak frequently?	
102 Clenching or grindinghabits?	
103 Do you hear popping, clicking or snapping?	
104 Do you have jaw pain?	
105 Are you nervous about dental work?	

Patient Signature:____Date:_____________

For Office Use Only

Dental Provider Acknowledgement:

I have reviewed the above medical, dental and social histories with the patient and have complete and accurate information to provide a clinical diagnosis and recommend appropriate treatment options.

Provider Signature:____Date: ____________________