PATIENT REGISTRATION

Date _____

Name _____

(Please Circle) Married Single Divorced Widowed Male Female

Street Address _____ City _____ State ___ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Circle phone number we should call to confirm appointments.

Date of Birth _____ Patient's Social Security Number _____

Employer of Patient _____

Spouse Name _____ Work Phone _____

Spouse's Employer _____ Spouse's DOB _____ Spouse's S.S. Number _____

Referred to our office by _____

Family members on this account _____

Person to be contacted in case of emergency _____ Phone # _____

Person Responsible for payment _____

Primary Dental Insurance Company Name _____ Secondary _____

Patients are responsible for payment of dental services at the time services are rendered. Dental insurance will be filed, but that is ultimately a contract between you and your insurance company and does not release you from obligation of payment. A 1½% finance charge (18% annually) will be added to any balance over 60 days. I understand and agree to the previous statement.

Signature _____ Date _____

DENTAL HISTORY

DATE OF LAST DENTAL VISIT	DATE OF LAST DENTAL CLEANING	DATE OF LAST X-RAYS

1. Have you had recent x-rays with a previous dentist? ❑ YES ❑ NO

   If so, what office? _____

2. Do you have any teeth that are sensitive? ❑ YES ❑ NO

3. Have you ever had:

   A. Orthodontic Treatment? ❑ YES ❑ NO

   B. Oral Surgery? ❑ YES ❑ NO

   C. Periodontal Treatment? ❑ YES ❑ NO

4. Do you suffer from pain and/or swelling of your gums? ❑ YES ❑ NO

5. Do your gums often bleed when you brush your teeth? ❑ YES ❑ NO

6. Have you experienced problems of the jaw? ❑ YES ❑ NO

7. Do you clench or grind your teeth while awake or asleep? ❑ YES ❑ NO

   If so, do you have a night guard? ❑ YES ❑ NO

8. Do you mouth breathe while awake or asleep? ❑ YES ❑ NO

9. Do you experience excessive dry mouth? ❑ YES ❑ NO

(PLEASE TURN OVER)

MEDICAL HISTORY

1. Primary Care Physician's Name _____

   Address _____ Telephone _____

2. Have you taken steroids or a bisphosphonate derivative (ie. Fosamax, Zometa, Boniva, etc. in the past two (2) years? YES NO

3. List all the medications you are currently taking (including OTC medications) _____

   _____

4. Are you aware of being allergic to or have you ever reacted adversely to any medication or dental anesthetic? YES NO

   If so, please list: _____

5. Do you have any dental problems now? _____

6. Is there anything you would like to change about the appearance of your teeth? _____

   _____

7. Indicate which of the following you have or have had? Circle "YES" or "NO" to each item.

Mitral Valve Prolapse	YES	NO	Artificial Heart Valve	YES	NO	Heart Murmur	YES	NO
Congenital Heart Defect	YES	NO	Rheumatic Fever	YES	NO	Artificial Joints	YES	NO
Infective Endocarditis	YES	NO				(hip, knee, etc.)		

If you marked YES to any of the above, do you take an antibiotic before dental work? YES NO

What antibiotic do you take? _____

Heart Disease or Attack	YES	NO	Hepatitis B or C	YES	NO	Asthma	YES	NO
Heart Pacemaker	YES	NO	Venereal Disease	YES	NO	Arthritis	YES	NO
Heart Failure	YES	NO	AIDS	YES	NO	Drug Addiction	YES	NO
Angina Pectoris	YES	NO	HIV Positive	YES	NO	Psychiatric		
High Blood Pressure	YES	NO	Blood Transfusion	YES	NO	Treatment	YES	NO
Diabetes	YES	NO	Hemophilia	YES	NO	Cold Sores /		
Stroke	YES	NO	Anemia	YES	NO	Fever Blisters	YES	NO
Kidney Trouble	YES	NO	Liver Disease	YES	NO	Latex Allergy	YES	NO
Thyroid Problems	YES	NO	Epilepsy or Seizures	YES	NO	Use Tobacco	YES	NO
Glaucoma	YES	NO	Cancer or Tumor	YES	NO	Sarcoidosis	YES	NO
Emphysema	YES	NO	Radiation Therapy	YES	NO			
Ulcers	YES	NO	Chemotherapy	YES	NO			
Tuberculosis	YES	NO						

8. Do you have, or have you had, any disease, condition, or problem not listed? YES NO

   If yes, please list: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Signature _____ Date _____