



# Patient Registration

Today's Date: \_\_\_\_\_

Thank you for filling out this form completely. If you have any questions at any time, please ask us.

## Patient Information

Name: \_\_\_\_\_  
Last First mi Mr Mrs Ms Dr

I prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Apt/Condo

\_\_\_\_\_  
city State Zip

Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_

\_\_\_\_\_  
city State Zip

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

E-mail

If we need to reach you during the day, which number should we call?:

Are you married? \_\_\_\_\_

## Spouse/roommate Information:

His / Her Name: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell \_\_\_\_\_

Name & number of relative or friend not living with you

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

In the event of an emergency, whom should we contact?

## Person Responsible for Account if different from patient:

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ Social Security: \_\_\_\_\_

Billing Address if different from patient: \_\_\_\_\_

\_\_\_\_\_

How did you hear about us? \_\_\_\_\_

If referred, by whom? \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

# Clinical History

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## Why have you come to the dentist today?

Are you currently in pain? Yes No Does food get caught between your teeth? Yes No  
Have you ever had periodontal disease? Yes No Do you need to be premedicated before dental work? Yes No  
Do you have frequent headaches? Yes No Do you use anything in addition to your brush and floss? Yes No  
Do you floss daily? Yes No Have you experienced problems with any previous dental work? Yes No  
Brush daily? Yes No How long do you use a toothbrush before replacing it? \_\_\_\_\_  
Do your gums ever bleed? Yes No Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_  
Do you use an electric toothbrush? Yes No Type of bristles on your toothbrush? Hard Medium Soft  
Do you now or have you ever experienced pain /discomfort in your jaw joint (TMJ / TMD)? Yes No If yes, why? \_\_\_\_\_

## Are you allergic to any of the following?

Aspirin Y N Erythromycin Y N Sedatives Y N Barbiturates Y N Jewelry Y N  
Sulfa Drugs Y N Codeine Y N Latex Y N Tetracycline Y N Dental Anesthetics Y N  
Penicillin Y N Other \_\_\_\_\_

Are you taking birth control pills? Yes No Are you pregnant? Unsure Yes No Week #: \_\_\_\_\_ Are you nursing? Yes No

## Are you taking any of the following?

Acetaminophen Yes No Blood Pressure Medication Yes No Recreational Drugs Yes No  
Antibiotics Yes No Cold Remedies Yes No Steroids / Cortisone Yes No  
Antihistamines Yes No Digitalis / Heart Medication Yes No Thyroid Medicine Yes No  
Aspirin Yes No Insulin / Diabetes Drugs Yes No Tranquilizers Yes No  
Blood Thinners Yes No Nitroglycerin Yes No

Oral or IV Bisphosphonates (for osteoporosis or cancer) Yes No

Are you taking any prescription/over-the-counter drugs not listed above? Yes No If yes, please list each one: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_ city \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit: \_\_\_\_\_

**Your current physical health is:** Good Fair Poor Are you currently under the care of a physician? Yes No

Please explain: \_\_\_\_\_

Do you smoke or use tobacco in any other form? Yes No Have you ever had a blood transfusion? Yes No

## Have you experienced the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Fainting Spells	Y N Pacemaker	Y N Alcohol Abuse
Y N Fever Blisters	Y N Persistent Cough	Y N Anemia	Y N Frequent Headaches
Y N Psychiatric Problems	Y N Arthritis	Y N Glaucoma	Y N Radiation Treatment
Y N Artificial Bones / Joints	Y N Hay Fever	Y N Rheumatic Fever	Y N Venereal Disease
Y N Artificial Valves	Y N Heart Attack	Y N Scarlet Fever	Y N Mitral Valve Prolapse
Y N Asthma	Y N Osteoporosis	Y N Seizures	Y N Epilepsy
Y N Blood Transfusion	Y N Heart Surgery	Y N Severe Headaches	Y N Ulcers
Y N Cancer	Y N Hemophilia	Y N Shingles	Y N Low Blood Pressure
Y N Chemotherapy	Y N Hepatitis	Y N Sickle Cell Disease	Y N Emphysema
Y N Chicken Pox	Y N Herpes / Fever Blisters	Y N Sinus Problems	Y N Tuberculosis (TB)
Y N Colitis	Y N High Blood Pressure	Y N Steroid Therapy	Y N liver Disease
Y N Congenital Heart Defect	Y N HIV+ / AIDS	Y N Stroke	Y N Drug Abuse
Y N Diabetes	Y N Hospitalized for Any Reason	Y N Thyroid Problems	Y N Tonsilitis
Y N Difficulty Breathing	Y N Kidney Problems		

Please list any serious medical condition(s) that you have experienced \_\_\_\_\_

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status or contact information.

Signature \_\_\_\_\_

Date \_\_\_\_\_