PATIENT REGISTRATION

NAME____

HOME ADDRESS______________________________________

CITY____________________________STATE______ZIP CODE__________

HOME TELEPHONE #__________________________________

WORK PHONE #____________________CELL PHONE #________________

E-MAIL ADDRESS____________________________________

BIRTH DATE______________________SS#__________________________

REFERRED BY_______________________________________

EMERGENCY CONTACT__________________PHONE #________________

REASON FOR VISIT__________________________________

EMPLOYER____

ADDRESS____

DENTAL INSURANCE__________________________________

SUBSCRIBER'S NAME_________________________________

SUBSCRIBER'S BIRTH DATE ______________ID#______________________

SECONDARY INSURANCE_______________________________

SUBSCRIBER'S NAME_________________________________

SUBSCRIBER'S BIRTH DATE______________ID#______________________

I UNDERSTAND THAT MY INSURANCE IS AN AGREEMENT BETWEEN MY INSURANCE COMPANY AND ME. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR THE BALANCE OF MY DENTAL ACCOUNT REGARDLESS OF MY INSURANCE. INITIAL________________

	YES	NO

ARE YOU **ALLERGIC** TO OR HAVE YOU EVER HAD REACTIONS TO ANY OF THE FOLLOWING:

	YES	NO
LOCAL ANESTHETICS LIKE NOVOCAINE	( )	( )
PENICILLIN OR OTHER ANTIBIOTICS	( )	( )
SULFA DRUGS	( )	( )
BARBITUATES OR SEDATIVES	( )	( )
ASPIRIN	( )	( )
IODINE	( )	( )
ANY METALS (NICKEL, MERCURY)	( )	( )
LATEX / RUBBER	( )	( )
OTHER______________________	( )	( )

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

	YES	NO
RHEUMATIC FEVER	( )	( )
CHEST PAIN	( )	( )
HEART DEFECT / MURMUR / ATTACK	( )	( )
STROKE	( )	( )
MITRAL VALVE PROLAPSE	( )	( )
HEART SURGERY	( )	( )
PACEMAKER	( )	( )
HIGH / LOW BLOOD PRESSURE	( )	( )
CONGENITAL HEART PROBLEM	( )	( )
FAINTING OR DIZZY SPILLS	( )	( )
DIABETES	( )	( )
AIDS OR HIV INFECTIONS	( )	( )
THYROID PROBLEMS	( )	( )
ALLERGIES	( )	( )
ARTHRITIS / RHEUMATISM	( )	( )
JOINT REPLACEMENT	( )	( )
STOMACH ULCER	( )	( )
TUBERCULOSIS	( )	( )
KIDNEY TROUBLE	( )	( )
EPILEPSY OR SEIZURES	( )	( )
CHEMOTHERAPY (CANCER / LEUKEMIA)	( )	( )
ANEMIA	( )	( )
GLAUCOMA	( )	( )
TONSILLITIS	( )	( )
TUMORS	( )	( )
MENTAL HEALTH CARE	( )	( )
CHEMICAL DEPENDENCY	( )	( )
COLD SORES / FEVER BLISTER	( )	( )
ASTHMA OR HAY FEVER	( )	( )
HEPATITIS OR LIVER DISEASE	( )	( )
SINUS TROUBLE	( )	( )

	YES	NO
DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	( )	( )
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	( )	( )
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	( )	( )
DO YOU HAVE FREQUENT HEADACHES?	( )	( )
DO YOU CLENCH OR GRIND YOUR TEETH?	( )	( )
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH?	( )	( )
HAVE YOU EVER HAD PERIODONTAL TREATMENT ? (GUMS)	( )	( )
HAVE YOU EVER WORN A BITE PLATE OR OTHER APPLIANCE?	( )	( )
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS?	( )	( )

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW :

CLICKING?______________________ PAIN (JOINT, EAR, SIDE OF FACE)?______________________

DIFFICULTY IN OPENING OR CLOSING?__________ DIFFICULTY IN CHEWING?______________________

DO YOU WEAR DENTURES OR PARTIALS? __________ IF YES, DATE OF PLACEMENT______________________

1. ARE YOU IN GOOD HEALTH?____Y N

2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?____________________________________Y N

3. PHYSICIAN'S NAME____

ADDRESS____

PHONE #____

4. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?______________________________________Y N

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5. ARE YOU TAKING ANY MEDICATIONS? ANY NON-PRESCRIPTION?__ Y N
PLEASE LIST:____

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6. HAVE YOU EVER HAD ANY ABNORMAL BLEEDING?______________ Y N

7. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?____________ Y N

8. DO YOU USE TOBACCO?_____________________________________Y N

9. ARE YOU WEARING CONTACT LENSES?__________________________Y N

10 DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT?_____________ Y N

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WOMEN ONLY:

ARE YOU PREGNANT? OR THINK YOU MAY BE?_____________ Y N
ARE YOU NURSING?__________________________________Y N
ARE YOU TAKING BIRTH CONTROL?______________________Y N

LAST DENTAL VISIT______________________LAST X-RAYS?________________

SIGNATURE____DATE__________