PATIENT REGISTRATION

Patient's Name _____Today's Date _____
Date of birth_____ Age_____
☐ Single ☐ Married

Home Address _____
_____zip

Patient employed by _____
Business Address _____
_____zip

Present Position _____

Phone: _____ home _____ work _____ cell

Social Security Number _____
Driver's License Number _____
Who will pay this account _____
Who referred you to our office _____
Reason for today's visit _____

Someone to notify in case of emergency
_____ _____ phone

Primary Dental Insurance
_____
_____
subscriber_____
policy #_____

Secondary Dental Insurance
_____
_____
subscriber_____
policy #_____

SPOUSE INFORMATION

Name of Spouse_____
Spouse employed by_____
Present Position_____
Spouse's Social Security Number_____
Spouse's Birthdate_____

DENTAL INFORMATION

Name of previous dentist _____

	YES	NO
Do you want complete dental care?	☐	☐
Are you satisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Are you currently in any discomfort?	☐	☐
Do you have TMJ or jaw pain?	☐	☐

MEDICAL INFORMATION

Name of physician _____ _____ telephone #

Do you have or have you ever had:

		YES	NO
High blood pressure		☐	☐
Diabetes		☐	☐
Tuberculosis		☐	☐
Hepatitis		☐	☐
Tests for the HIV virus		☐	☐
Abnormal bleeding from a cut		☐	☐
Abnormal heart condition		☐	☐
Artificial heart valve		☐	☐
Pacemaker		☐	☐
Artificial joints		☐	☐
Radiation therapy for cancer		☐	☐
Allergies to:	Aspirin	☐	☐
	Acetaminophen	☐	☐
	Ibuprofen	☐	☐
	Penicillin	☐	☐
	Erythromycin	☐	☐
	Local anesthesia	☐	☐
	Latex	☐	☐
	Anything else _____		
Do you smoke?		☐	☐
Are you or could you be pregnant?		☐	☐

What medications are you taking?

_____

Are there any other dental or medical concerns we should be aware of?

_____

Updates:

_____
_____
_____
_____
_____
_____