PATIENT REGISTRATION

Welcome! *Please complete the following confidential information*

PATIENT INFORMATION

NAME _____
(First) (Middle) (Last)

SOCIAL SECURITY # _____ DATE OF BIRTH _____ Age _____ Sex: M F

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

HOME PHONE _____ EMAIL ADDRESS _____

EMPLOYER: _____ WORK PHONE _____ EXT _____

IF PATIENT IS A MINOR, PARENT OR GUARDIAN'S NAME _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____ DRIVER'S LICENSE NO. _____

EMPLOYER: _____ WORK PHONE _____ EXT _____

EMERGENCY CONTACT: _____ PHONE _____ RELATIONSHIP _____

HOW DID YOU HEAR ABOUT US? (CHECK ONE)

□ Yellow Pages □ Family- Friend □ Flyer-Coupon □ Radio □ Office Sign □ Health Fairs □ Insurance Plan
□ Internet □ Mail-Postcard □ Bill Board □ Employee □ Newspaper □ Other _____

DENTAL HISTORY

Reason for Visit / Main Concern? Check-Up □ Cleaning □ Toothache □ Other _____

Date of last dental visit _____ Reason _____

Have you ever had a bad experience in a dental office that you would like to tell us about? YES □ NO □ If yes, please explain _____

Does your gum bleed, feel tender or irritated? YES □ NO □ Are your teeth sensitive to hot, cold, sweets or pressure? YES □ NO □

MEDICAL HISTORY

Are you under a Physician's care at this time? YES □ NO □ If yes, please specify _____

Name of Physician _____ Phone _____

What medications are you currently taking? _____

Are you taking any of the following? Warfarin □ Plavix □ Bisphosphonate □ Cortisone □

If female, are you pregnant at this time? YES □ NO □ If yes, how many months? _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING? (Check all that apply)

□ Artificial Heart Valve	□ Bruise Easily	□ Fainting or Dizzy Spells	□ Kidney Trouble	□ Pain in Jaw Joints
□ Anemia	□ Bone Disease	□ Glaucoma	□ Liver Disease	□ Sickle Cell Disease
□ Arthritis	□ Cancer/ Leukemia	□ Heart Disease _____	□ Lung Disease	□ Smoking Tobacco
□ Asthma	□ Chemo/ Rad Therapy	□ Hemophilia	□ Nervousness	□ Stroke
□ AIDS/ HIV+	□ Diabetes	□ Hepatitis Type ____	□ Neurological Disorders	□ Thyroid Problems
□ Angina	□ Emphysema	□ High Blood Pressure	□ Osteoporosis	□ Tuberculosis
□ Blood Disease	□ Epilepsy or Seizures	□ Joint Replacement	□ Pacemaker	□ Venereal Disease

Is there any other health problems not listed above of which we should be advised?

Please specify _____

Mark any of the following medications you are allergic to:

□ Local Anesthetics	□ Penicillin or other antibiotic	□ Sulfa Drugs	□ Aspirin	□ Iodine
□ Latex	□ Codeine or other narcotics	□ Barbiturates, sedatives	□ Other _____	

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

Patient/Guardian's Signature _____ **Date** _____

Doctor's Signature _____ **Date** _____