Dental Registration and History

1 PATIENT INFORMATION

Date_____

SS#/Patient ID#_____

Patient Name_____
Last Name

_____
First Name Middle Initial

Address_____

City_____

State_____Zip _____

E-mail_____

Sex ☐ M ☐ F Age_____

Birthdate_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

2 DENTAL INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Company_____

Group #_____

Is patient covered under additional insurance? ☐ Yes ☐ No

Subscriber's name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Company_____

Group#_____

3 PHONE NUMBERS

Home (_____)_____ Cell (_____)_____

Work (_____)_____ ext _____

Spouse's Work (_____)_____ ext _____

Best Time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household)

Name _____

Relationship _____

Home (_____)_____ Cell (_____)_____

Work (_____)_____ ext_____

Preferred Pharmacy _____

Pharmacy Phone (_____)_____

4 DENTAL HISTORY

Reason for today's visit _____ Former Dentist_____

City/State _____ Date of last dental visit_____ Date of last dental x-rays_____

Place a mark on "yes" or "no" to indicate if you have had any of the following.

	Yes	No
Bad breath	☐	☐
Bleeding gums	☐	☐
Blisters on lips or mouth	☐	☐
Broken fillings or teeth	☐	☐
Chew on one side of mouth	☐	☐
Dental implants	☐	☐
Dry Mouth	☐	☐
Food collecting between teeth	☐	☐
Grind or clench teeth	☐	☐

	Yes	No
Gums swollen or tender	☐	☐
Jaw pain or clicking or popping	☐	☐
Pain around ear	☐	☐
Loose teeth	☐	☐
Orthodontic treatment	☐	☐
Periodontal treatment	☐	☐
Sensitivity to cold	☐	☐
Sensitivity to heat	☐	☐
Sensitivity to sweets	☐	☐

	Yes	No
Sensitivity when biting	☐	☐
Sore muscles of face	☐	☐
Sores or growths in your mouth	☐	☐
Nervous about seeing a dentist	☐	☐
Wear partials or dentures	☐	☐
Would you like nitrous oxide ?	☐	☐

How often do you floss? _____ per day

How often do you brush? _____ per day

TURN OVER

Dental Registration and History

5 HEALTH HISTORY

Physician's Name / Office #_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as : Yes No

1) "fen-phen" these include combinations of Ionimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine) ☐ ☐
2) Bisphosphonates for bone loss or osteoporosis – Boniva, Fosamax, Evista, Etc. ☐ ☐

Place a mark on "yes" or "no" to indicate if you have had any of the following.

	Yes	No
AIDS/HIV	☐	☐
Alcohol intolerance	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial heart valves	☐	☐
Artificial joints	☐	☐
Date of surgery _____		
Asthma or Hay Fever	☐	☐
Back problems	☐	☐
Bleeding abnormally, with extractions or surgery	☐	☐
Blood disease	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Congenital heart lesions	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐

	Yes	No
Diabetes	☐	☐
Sugar level this morning _____		
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting or dizziness	☐	☐
Head aches	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis type _____	☐	☐
Herpes	☐	☐
High blood pressure	☐	☐
Jaw pain	☐	☐
Kidney disease	☐	☐
Liver disease	☐	☐
Low blood pressure	☐	☐
Mitral valve prolapse	☐	☐
Nervous problems	☐	☐
Neurological problems	☐	☐
Pacemaker or Defibrillator	☐	☐
Psychiatric care	☐	☐
Radiation Treatment	☐	☐

	Yes	No
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Seizures	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐
Skin rash or hives	☐	☐
Stroke	☐	☐
Swollen neck glands	☐	☐
Thyroid problems	☐	☐
Tuberculosis	☐	☐
Tumor or growth	☐	☐
Ulcers	☐	☐
Venereal Disease	☐	☐
Weight loss, unexplained	☐	☐
X-ray exposure at work	☐	☐
Do you wear contact lenses?	☐	☐
WOMEN		
Pregnant? Due date _____	☐	☐
Are you nursing ?	☐	☐

6 MEDICATIONS

List any medications you are taking and why. _____

_____

_____

_____

ALLERGIES

☐ Aspirin ☐ Barbiturates ☐ Codeine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa ☐ Ibuprofen

☐ Other _____

7 SIGNATURE

X _____ X _____ _____ _____

Signature (parent if minor) DATE Dr's initails date

I acknowledge I have received a copy of the office **Notice of Privacy Practice** X _____date_____

I acknowledge I have received a copy of the **Dental Materials Fact Sheet** as required by law X _____date_____