

Patient Registration Information Form

Date: _____ Driver's License # _____

Patient Name _____ Birth Date _____ Age _____

Preferred name you would like us to use _____

Parent and or Guardian Name _____

Address _____ Zip Code _____

Home Phone Number _____ Work Phone Number _____ (ext) _____

Cell Phone Number _____ E-Mail Number _____

Social Security Number _____ Minor Single Married Widowed

Employed By: _____ Occupation _____

Spouse Name: _____ Spouse Birth Date _____

Spouse Employed By: _____ Occupation _____

Spouse Social Security Number: _____

Person to contact in emergency _____ Phone _____

Do you have Dental Insurance? Yes No Does your Spouse? Yes No

Name of your dental carrier? _____ Name of Spouse dental carrier? _____

How Did You Find Out About Our Office: (Circle Number)

- 1. Referred By Patient. Who _____ 2. Brochure 3. Newspaper. Which? _____
4. Office Sign 5. Internet 6. Yellow Pages. Which One? _____
7. Referred by one of our employees. Who? _____ 8. Other Source? _____

If Student, Name of School/College -Full or Part Time (circle one) _____

METHOD OF PAYMENT

Please check one of the following:

- _____ Payment in full at each appointment
_____ Co.-payment in full at each appointment
_____ Credit Card
_____ Debit Card

Patient Signature _____
(Parent or Guardian)

Dental History

Last Dental Visit was on _____ Reason _____

Were x-rays taken? Yes No

Previous Dentist _____ Phone Number _____

Why did you leave your last dental practice? _____

How do you react to Dental Care? Dread it _____ Worry about it _____ Don't mind it _____

By asking these questions we will be able to better understand your previous dental experiences, your dental concerns and dental goals, short term and long term.

Please, help us understand your daily oral hygiene care, please check appropriate boxes

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Manual Tooth Brush | <input type="checkbox"/> Electric Tooth Brush | <input type="checkbox"/> Floss | <input type="checkbox"/> Floss Threader |
| <input type="checkbox"/> Proxabrush | <input type="checkbox"/> Waterpik | <input type="checkbox"/> Rubber Tip | <input type="checkbox"/> Stimudents |
| <input type="checkbox"/> Fluoride gel /rinses | <input type="checkbox"/> Mouth Wash | <input type="checkbox"/> Tongue Scraper | <input type="checkbox"/> Other |

How often do you brush? 1x daily 2x daily 3x daily

YES NO Please check appropriate box:

- Are you experiencing pain or discomfort from your mouth at this time? If so, where?
Lower Right Lower Left Upper Right Upper Left
- Are there any areas in your mouth that are sensitive to hot/cold/sweet? If so, where?
Lower Right Lower Left Upper Right Upper Left
- Have you ever been told by your previous dentist you have periodontal disease?
- Have your parents experienced gum disease or tooth loss?
- Have you noticed any loose teeth or change in your bite?
- Have you noticed any soreness or tenderness on your gum tissue at times?
- Do you ever notice any bleeding of your gum tissue when you are brushing your teeth?
- Do you experience a bad taste in your mouth during the daytime hours?
- Are you aware of any lumps in your mouth?
- Do you chew on one side / both sides or have difficulty chewing the foods you love?
- Do you find yourself avoiding some foods because they may get caught between your teeth?
- Do you consume a high content of sugary foods or drinks?
- Do you clench or grind your teeth in the daytime or night?
- Do your jaws feel tired after eating? After you wake up in the morning? YES NO
- Do you ever hear popping or clicking sounds when you chew? If so, where? _____
- Have you had a night guard made for you?
- Do you have dental implants?
- Do you wear partials or dentures? If so, how old are they? _____
- Have you ever had prolonged bleeding following extractions in the past?
- Have you ever worn braces to straighten your teeth?
- Would you be interested in having straighter teeth without involving orthodontics/braces?
- Is there anything about the appearance and or function of your teeth you would like changed?
- Would you like to know about the different types of cosmetic options available to you in dentistry?
- On a scale from one to ten, how would you rate your mouth (ten is the best)? _____

Medical History

Are you under the care of a physician? _____ If yes, Condition _____

< When was your last physical examination? _____

< Have you been hospitalized or had a serious illness within the last five years? ____ If yes, what was the problem? _____

< _____

< Have you been advised by a physician to pre-medicate with an antibiotic prior to having dentistry? Yes No

< Physician _____ Phone _____

List of current medications

Reasons

Are you allergic to, or have had any unusual reactions to any of the following:

Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Dental Anesthetic	<input type="checkbox"/> <input type="checkbox"/> Metronidazole	<input type="checkbox"/> <input type="checkbox"/> Aspirin
<input type="checkbox"/> <input type="checkbox"/> Penicillin or any Antibiotic	<input type="checkbox"/> <input type="checkbox"/> Codeine	<input type="checkbox"/> <input type="checkbox"/> Latex
<input type="checkbox"/> <input type="checkbox"/> Erythromycin	<input type="checkbox"/> <input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> <input type="checkbox"/> Other

Do you have or have you had any of the following? (Please check appropriate conditions)

Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Heart Trouble/ Disease	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> <input type="checkbox"/> Heart Attack/ Failure	<input type="checkbox"/> <input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> <input type="checkbox"/> Artificial Joints/Pins/ Plates
<input type="checkbox"/> <input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> <input type="checkbox"/> Rheumatism	<input type="checkbox"/> <input type="checkbox"/> Dental Implants
<input type="checkbox"/> <input type="checkbox"/> Angina/Chest Pain	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> <input type="checkbox"/> Bruise Easily
<input type="checkbox"/> <input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Aids/HIV
<input type="checkbox"/> <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> <input type="checkbox"/> Tumors/Growths	<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A Infectious	<input type="checkbox"/> <input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Hepatitis B Infectious	<input type="checkbox"/> <input type="checkbox"/> Cortisone/Hormonal therapy
<input type="checkbox"/> <input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> <input type="checkbox"/> Hepatitis C	<input type="checkbox"/> <input type="checkbox"/> Do you smoke? ____per day
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Hepatitis D	<input type="checkbox"/> <input type="checkbox"/> Do you use smokeless tobacco?
<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Hepatitis E	<input type="checkbox"/> <input type="checkbox"/> Use prescription diet pills
<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> Drug Addiction
<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> <input type="checkbox"/> Hemophilia (Bleeding Problem)	<input type="checkbox"/> <input type="checkbox"/> Controlled	<input type="checkbox"/> <input type="checkbox"/> Nervousness
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Uncontrolled	<input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Insulin Dependent	<input type="checkbox"/> <input type="checkbox"/> Night Sweats
<input type="checkbox"/> <input type="checkbox"/> Asthma		

Do you have any disease, condition or other problems I should know about, not listed above?

Women Only Are you pregnant? _____ If so how many months? _____ Due Date _____

To the best of my knowledge, all the proceeding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment.

Date: _____

Patient Signature (Parent or Guardian) _____

FOR OFFICE USE ONLY

Hard and Soft Tissue Oral Cancer Exam

Normal _____ Abnormal _____ If abnormal, give discription _____

Dentist Signature

Date

Hygienist Signature

Date

