DENTAL REGISTRATION AND HISTORY

Please print clearly and circle appropiate answers

PATIENT INFORMATION

Date _____

Name _____

Last First MI Prefered Name

Address _____

City _____

State _____ Zip _____

Birthdate _____ Age _____

SSN _____

Gender M F Single Married Widowed Child

Employer/School _____

Occupation _____

Spouse's Name _____

Parent's Name _____
(If Minor)

Whom may we thank for referring you?

_____

DENTAL INSURANCE

Primary Insurance Co _____

Subscriber _____

Secondary Insurance Co _____

Subscriber _____

CONTACT INFORMATION

Home ( ) _____

Work ( ) _____ Ext _____

Cell ( ) _____

Email _____

In Case of Emergency

Name _____

Relationship _____

Phone/Work # _____

DENTAL HISTORY

Reason for visit _____

Please circle Y-"yes" or N-"no" to indicate if you have/had any of the following:

Bad breath	Y	N
Bleeding gums	Y	N
Blisters on lips or gums	Y	N
Burning sensation on tongue	Y	N
Chew on one side of mouth	Y	N
Clicking or popping jaw	Y	N
Dry mouth	Y	N
Fingernail biting	Y	N
Food collection between teeth	Y	N
Grinding/clinching teeth	Y	N
Gums swollen or tender	Y	N
Jaw pain or tiredness	Y	N
Lip or cheek biting	Y	N
Loose teeth or broken fillings	Y	N
Orthodontic treatment	Y	N
Pain around ear	Y	N
Pain when biting	Y	N
Pain when brushing	Y	N
Periodontal treatment	Y	N
Sensitivity to cold	Y	N
Sensitivity to heat	Y	N
Sensitivity to sweets	Y	N
Sores or growths in your mouth	Y	N
Use of CPAP (for Sleep Apnea)	Y	N
Use of tobacco products	Y	N

Type? _____ **Packs/ Usage per a day?** _____

How often do you brush ?_____ How often do you floss?_____

OVER

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Phone ( ) _____

Please circle Y-"yes" or N-"no" to indicate if you have/had any of the following:

Anemia	Y	N	Low Blood Pressure	Y	N	Some patients will require a pre-treatment of antibiotics prior to dental procedures, please circle Y-"yes" or N-"no" to indicate if you have had any of the following:	
Arthritis, Rheumatism	Y	N	Neurological Problems	Y	N		
Asthma	Y	N	Psychiatric Care	Y	N		
Anxiety	Y	N	History of Radiation				
Back Problems	Y	N	Treatment	Y	N		
Cancer	Y	N	Shortness of Breath	Y	N		
Type?: _____ Status _____			Sinus Trouble	Y	N	Artificial Heart Valves	Y N
Cough (persistent)	Y	N	Skin Rash	Y	N		
Diabetes	Y	N	Rapid Weight Gain/Loss	Y	N		
Emphysema/ COPD	Y	N	Stroke	Y	N	Artificial Joint Replacement	Y N
Epilepsy	Y	N	Swollen Neck Glands	Y	N		
Fainting or dizziness	Y	N	Thyroid Problems	Y	N		
Gastric Reflux (GERD)	Y	N	Tuberculosis	Y	N	Congenital Heart Disease	Y N
Glaucoma	Y	N	Tumors or Growths	Y	N		
Headaches	Y	N	Stomach Ulcer	Y	N		
Hepatitis Type _____	Y	N	Other: _____			Previous Infective Endocarditis	Y N
Herpes	Y	N	_____				
High Blood Pressure	Y	N					
HIV Positive	Y	N	**Have you been hospitalized or had any surgery since your last dental visit? Y N**				
Jaundice	Y	N					
Kidney Disease	Y	N	**Women:** Are you pregnant? Y N Due date_____				
Liver Disease	Y	N	Are you nursing? Y N Are you taking birth control pills? Y N				

Allergies

☐ None	☐ Aspirin	☐ Other _____
☐ Penicillin	☐ Barbiturates	
☐ Latex	☐ Iodine	
☐ Local Anesthetic	☐ Metal	
☐ Sulfa	☐ Codeine	

MEDICATIONS

Please *print* all medications (Prescription or Non-Prescription) you are currently taking:

Patient/Guardian Signature _____ **Date** _____