# 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

- ❑ Manual Tooth Brush
- ❑ Electric Tooth Brush
- ❑ Floss
- ❑ Floss Threader
- ❑ Proxabrush
- ❑ Waterpik
- ❑ Rubber Tip
- ❑ Stimudents
- ❑ Fluoride gel /rinses
- ❑ Mouth Wash
- ❑ Tongue Scraper
- ❑ 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 | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Dental Anesthetic | ❑ | ❑ | Metronidazole | ❑ | ❑ | Aspirin |
| ❑ | ❑ | Penicillin or any Antibiotic | ❑ | ❑ | Codeine | ❑ | ❑ | Latex |
| ❑ | ❑ | Erythromycin | ❑ | ❑ | Sulfa Drugs | ❑ | ❑ | Other |

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

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

## Additional Information

| Medical Update | Signature | Medical Update | Signature |
| --- | --- | --- | --- |
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