Patient Registration Form

Date:_____ SSN:_____ Date of Birth:_____ Sex: Male ☐ Female ☐

Patient Name: _____
First Name Last Name Middle Initial

Address:_____ City:_____ State: _____ Zip: _____

Home Number: _____ Work Number: _____ Cell Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated E-Mail:_____

☐ Minor ☐ Widowed ☐ Partnered for ____years

Patient Employer/School: _____ Occupation: _____

Insurance Information

Responsible Party: _____ Relationship to Patient:_____

Insurance Co.: _____ Policy Holder's Name: _____

Date of Birth: _____ SSN:_____ Employer: _____

Insurance ID#: _____ Group Number: _____

Secondary Insurance?

Responsible Party: _____ Relationship to Patient:_____

Insurance Co.: _____ Policy Holder's Name: _____

Date of Birth: _____ SSN:_____ Employer: _____

Insurance ID#: _____ Group Number: _____

Dental History:

Reason for Today's Visit: _____ Former Dentist: _____

City/State: _____ Date of Last Dental Visit: _____ Date of Last X-Rays: _____

Check "yes" or "no" to indicate the following:

Yes ☐ No ☐ Bad breath
Yes ☐ No ☐ Bleeding Gums
Yes ☐ No ☐ Burning sensation on tongue
Yes ☐ No ☐ Cigarette, pipe or cigar smoking
Yes ☐ No ☐ Clicking or popping jaw
Yes ☐ No ☐ Dry mouth
Yes ☐ No ☐ Food collection between teeth
Yes ☐ No ☐ Grinding teeth
Yes ☐ No ☐ Swollen or tender gums
Yes ☐ No ☐ Jaw pain or tiredness
Yes ☐ No ☐ Loose teeth or broken fillings

Yes ☐ No ☐ Mouth Breathing
Yes ☐ No ☐ Orthodontic treatment
Yes ☐ No ☐ Periodontal treatment
Yes ☐ No ☐ Sensitivity to heat or cold
Yes ☐ No ☐ Sensitivity to sweets
Yes ☐ No ☐ Sensitivity when biting
Yes ☐ No ☐ Sores or growths in your mouth
How often do you floss? _____
How often do you brush?_____
Do you like your smile?_____

Whom May We Thank for Referring You?_____

Health Information Form

Patient's Name: _____ Date of Birth: _____

Physician's Name: _____ Date of Last Visit: _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
3. If yes, please explain: _____		
4. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, please list: _____ _____		
5. **Women Only:**		
Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

6. Are you allergic to or have you had any reactions to the following?	YES	NO
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other_____	☐	☐

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

YES	*NO*	
☐	☐	AIDS/HIV
☐	☐	Anemia
☐	☐	Arthritis, Rheumatism
☐	☐	Artificial Heart Valves
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Back Problems
☐	☐	Blood Disease
☐	☐	Cancer
☐	☐	Chemical Dependency
☐	☐	Chemotherapy
☐	☐	Circulatory Problems
☐	☐	Congenital Heart Lesions
☐	☐	Cortisone Treatments
☐	☐	Cough, persistent or bloody
☐	☐	Diabetes
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting or dizziness
☐	☐	Glaucoma
☐	☐	Headaches
☐	☐	Heart Murmur
☐	☐	Heart Problems
☐	☐	Hepatitis Type____

YES	*NO*	
☐	☐	Herpes
☐	☐	High Blood Pressure
☐	☐	Jaundice
☐	☐	Kidney Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Pro-lapse
☐	☐	Psychiatric Care
☐	☐	Radiation Treatment
☐	☐	Respiratory Disease
☐	☐	Rheumatic Fever
☐	☐	Scarlett Fever
☐	☐	Shortness of Breath
☐	☐	Sinus Trouble
☐	☐	Skin Rash
☐	☐	Special Diet
☐	☐	Stroke
☐	☐	Swollen Feet or Ankles
☐	☐	Swollen Neck Glands
☐	☐	Thyroid Problems
☐	☐	Tonsillitis
☐	☐	Tuberculosis
☐	☐	Tumor or growth
☐	☐	Ulcer
☐	☐	Venereal Disease