PATIENT REGISTRATION

Name________________________________ Date of Birth________________ Sex_________ Date__________________

Address____________________________ City__________________ Zip__________ Home Phone__________________

Mobile Phone______________ Social Security Number______________ Email__________________________________

Marital Status ___________________ Spouse's Name ____

Patient's Name (if child) ___________________________________Referred by__________________________________

Person responsible for Account _______________________________ Address__________________________________

Employer__________________________ Address___________________________ Bus. Phone___________________

Type of Dental Insurance (if applicable) ____

Medical History

1. Name and Address of Physician____
2. Are you under the care of a physician……… Yes No
3. Have you been treated for any serious illness in the past year……… Yes No
   a. If yes, what?____
4. Do you require premedication before your dental appointment?……… Yes No
5. Do you have ***any*** allergies (latex, medications, food, etc.)?……… Yes No
   a. If yes, please list____
6. Have you ever been treated for:

Heart Problems (heart attack, murmur, etc)	Yes	No	AIDS/ HIV………	Yes	No
Heart Valve Replacement or problems………	Yes	No	Tuberculosis………	Yes	No
Rheumatic Fever………	Yes	No	Liver or Kidney Disease………	Yes	No
High Blood Pressure………	Yes	No	Respiratory Disease………	Yes	No
Stroke………	Yes	No	Tobacco Use………	Yes	No
Diabetes………	Yes	No	Asthma, Hay Fever, Allergies………	Yes	No
Hepatitis………	Yes	No	Unusual or Prolonged Bleeding………	Yes	No
Joint Replacements (knee, hip, etc)………	Yes	No	Venereal Disease………	Yes	No
Epilepsy………	Yes	No	Tumors or Cancer………	Yes	No
Anemia………	Yes	No	Radiation Treatment………	Yes	No

7. Have you ever or are you currently taking any medication to treat or prevent osteoporosis (ie. Fosamax, Boniva, Actonel, etc.)?……… Yes No
8. Do you take any blood thinners (ie. Plavix, Coumadin/Warfarin, Aspirin, etc.)……… Yes No
9. Are you pregnant or think you may be pregnant? ……… Yes No
10. Have you ever been treated by a psychiatrist?……… Yes No
11. Do any diseases or conditions run in your family?____
12. Is there anything else about your health we should know about?___________________________________
13. Please list all medications that you take, both prescription and over the counter, including dosage:

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Dental History

1. What is the purpose of your visit today? ____
2. Have you ever had ulcers or sores inside your mouth or lips?……… Yes No
3. Have you ever had any injuries to your face, jaws, or teeth?……… Yes No
4. Are your teeth sensitive to cold, heat, or sweets?……… Yes No
5. Are your teeth sensitive to chewing or biting?……… Yes No
6. Do you have bleeding or swollen gums?……… Yes No
7. Do you have any loose teeth?……… Yes No
8. Have you ever had any problems following dental treatment or extractions?……… Yes No
9. Have you ever had a reaction to local anesthetic (ie. Novocaine, Xylocaine)?……… Yes No
10. Do you grind or clench your teeth?……… Yes No
11. Are you satisfied with the appearance of your teeth?……… Yes No
12. Are you nervous about dental treatment?……… Yes No
13. Are you familiar with "preventive dentistry"?……… Yes No
14. When was your last dental visit?____
15. Please add anything you feel is important for us to know: ___________________________________

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Signature:____ **Date**:___________________