PATIENT REGISTRATION

PLEASE PRINT CLEARLY **TODAY'S DATE:___________**

PATIENT'S INFORMATION

Last Name:____

First Name:_______________________________MI:_______

Title: ☐Mr. ☐Mrs. ☐Ms. ☐Dr. Gender: ☐M ☐F

Family Status: ☐Married ☐Single ☐Child ☐Other

Birth Date:____

Social Security #:_____________________________________

Driver's License #:____________________________________

Street Address:____

____

City:____

State:________________ Zip:___________________________

E-mail:____

☐I would like to receive correspondence via email.

Home Phone:____________________________________

Work Phone:_________________________Ext________

Cell Phone:______________________________________

Other Phone:_____________________________________

Emergency Contact Name:_________________________

Relationship to Patient:__________________________

Emergency Contact Phone:________________________

Emergency Contact Alternate Phone:_______________

____

Employer Name:____

Address:____

City:____

State:__________________ Zip:_________________________

Occupation:______________________________________

Years with Current Employer:______________________

Are you a full-time student? ☐Yes ☐No

If yes, School Attending:__________________________

RESPONSIBLE PARTY/INSURANCE POLICY HOLDER (if different than the patient)

Last Name:____

First Name:_______________________________MI:________

Title: ☐Mr. ☐Mrs. ☐Ms. ☐Dr. Gender: ☐M ☐F

Family Status: ☐Married ☐Single ☐Child ☐Other

Birth Date:____

Social Security #:______________________________________

Driver's License #:_____________________________________

Street Address:____

____

City:_____________________State:________Zip:____________

E-mail:____

☐I would like to receive correspondence via email.

Home Phone:____________________________________

Work Phone:_________________________Ext_________

Cell Phone:______________________________________

Other Phone:_____________________________________

Relationship to Patient:__________________________

☐Responsible Party is also the Insurance Policy Holder

☐Primary Insurance Policy Holder

☐Secondary Insurance Policy Holder

PRIMARY DENTAL INSURANCE

Policy Holder:____

Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Insurance Company:_____________________________________

Insurance Phone Number:________________________________

Insurance Address:______________________________________

City:________________________State:________Zip:__________

Group Plan Name:_______________________________________

Group Plan#:____

ID/SS Number:____

SECONDARY DENTAL INSURANCE

Policy Holder:______________________DOB: ___________

Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Insurance Company:___________________________________

Insurance Phone Number:______________________________

Insurance Address:____________________________________

City:______________________State:_______Zip:__________

Group Plan Name:_____________________________________

Group Plan#:____

ID/SS Number:____

Pharmacy Name: ____

Pharmacy Phone Number: ____

MEDICAL INFORMATION
Please check appropriate box with your response, ALL QUESTIONS MUST BE ANSWERED:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Alzheimer's/Dementia	☐	☐	Cough (type)________	☐	☐	Hepatitis (type)_______	☐	☐	Radiation Therapy	☐	☐
Anemia	☐	☐	Dermal Fillers	☐	☐	Herpes	☐	☐	Rheumatic/Scarlet Fever	☐	☐
Angina or Chest Pain	☐	☐	Diabetes (type)_______	☐	☐	Hiatal Hernia	☐	☐	Shortness of Breath	☐	☐
Arthritis/Rheumatism	☐	☐	Diarrhea, persistent	☐	☐	High/Low Blood Pressure	☐	☐	Sinus Infection/Disease	☐	☐
Asthma	☐	☐	Digestive Disorder	☐	☐	HIV/AIDS	☐	☐	Stroke (date)_________	☐	☐
Atrial Fibrillation	☐	☐	Dizziness, Fainting	☐	☐	Jaundice	☐	☐	Sjorgren's Syndrome	☐	☐
Bleeding Problems	☐	☐	Drug/Alcohol Addiction	☐	☐	Joint Replacement	☐	☐	Stomach Ulcer	☐	☐
Blood Disease	☐	☐	Dry Mouth	☐	☐	Kidney Disease	☐	☐	Swelling Feet/Ankles	☐	☐
Blood Thinners	☐	☐	Emphysema/Bronchitis	☐	☐	Leukemia/Lymphoma	☐	☐	Swollen Glands – Neck	☐	☐
Blood Transfusions	☐	☐	Epilepsy/Seizure	☐	☐	Liver Disease	☐	☐	Thyroid Disease	☐	☐
Bone Disease	☐	☐	Excessive urination	☐	☐	Lung Disease	☐	☐	TMJ/Jaw Pain	☐	☐
Cancer (type)________	☐	☐	Glaucoma	☐	☐	Mental Health Issues	☐	☐	Tuberculosis	☐	☐
Chemotherapy	☐	☐	Grinding or Clenching	☐	☐	Neck/Back Problems	☐	☐	Tumors/Growths	☐	☐
Cigarette/Tobacco use	☐	☐	Headaches	☐	☐	Osteoporosis	☐	☐	Valve Replacement	☐	☐
Circulation Problems	☐	☐	Heart Attack (date)_____	☐	☐	Pacemaker/Defibrillator	☐	☐	Venereal Disease	☐	☐
Contact Lenses	☐	☐	Heart Defect	☐	☐	Periodontal Disease	☐	☐	Vision/Hearing Impaired	☐	☐
Cortisone/Steroids	☐	☐	Heart Disease	☐	☐	Previous Endocarditis	☐	☐	Weight Loss, unexplained	☐	☐
Controlled substance use	☐	☐	Heart Murmur/LeakyValve	☐	☐	Psychiatric Care	☐	☐			

PROFESSIONAL

Do you have any disease, condition, or medical problem **NOT LISTED** that you think the office should know about? Please explain:____

Have you been told that you need to **PREMEDICATE** or take antibiotics prior to a dental procedure? ☐Yes ☐No
If yes, Which antibiotic do you take?____________________________ For what condition? __________________________

ALLERGIES To all yes responses specify type of reaction:

Local anesthetics or Epinephrine___________ ☐Yes ☐No
Aspirin_________________________________ ☐Yes ☐No
Penicillin or other antibiotics______________ ☐Yes ☐No
Barbiturates, sedatives or sleeping pills______ ☐Yes ☐No
Sulfa Drugs_____________________________ ☐Yes ☐No
Codeine or other narcotics________________ ☐Yes ☐No
Metals_________________________________ ☐Yes ☐No
Latex (rubber)___________________________ ☐Yes ☐No
Iodine__________________________________ ☐Yes ☐No
Other__________________________________ ☐Yes ☐No

MEDICATIONS List all medications you are currently taking, including over-the-counter drugs, such as vitamins and inhalers.

Drug__________________________Dose_________________ Drug_______________________ Dose________________
Drug__________________________Dose_________________ Drug_______________________ Dose________________
Drug__________________________Dose_________________ Drug_______________________ Dose________________
Drug__________________________Dose_________________ Drug_______________________ Dose________________

BLOOD THINNERS & BISPHOSPHONATES Do you take or have you taken any of the medications listed below?

Fosomax® (alendronate) ☐Yes ☐No Years_________
Actonel® (risedronate) ☐Yes ☐No Years_________
Boniva® (ibandronate) ☐Yes ☐No Years_________
Reclast® (zoledronic acid) ☐Yes ☐No Years_________
Embrel® (etanercept) ☐Yes ☐No Years_________
Aredia® (pamidronate) ☐Yes ☐No Years_________
Prolia® (denosumab) ☐Yes ☐No Years_________
Zometa® (zoledronate) ☐Yes ☐No Years_________
Humira® (adalimumad) ☐Yes ☐No Years_________
Remicade® (infliximab) ☐Yes ☐No Years_________
Blood Thinners (Plavix, Coumadin, Aspirin, Pradaxa, Effient) ☐Yes ☐No

PRIMARY MEDICAL PHYSICIAN	**SPECIALIST PHYSICIAN** (Cardiologist, Endocrinologist, etc)
Name:_______________	Name:_______________
Address:_______________	Address:_______________
City:__________ State:_______ Zip:_________	City:__________ State:_______ Zip:_________
Phone:_______________	Phone:_______________
Fax:_______________	Fax:_______________

When was your last physical examination?_______________

Are you currently under the care of a physician? ☐Yes ☐No

If yes, for what reason or condition?_______________

Have you had any surgery in the past three (3) years? ☐Yes ☐No

If yes, please explain:_______________

Have you been hospitalized in the last twelve (12) months? ☐Yes ☐No

If yes, please explain:_______________

WOMEN ONLY:

Is there a possibility that you are pregnant? ☐Yes ☐No

Are you pregnant or nursing? ☐Yes ☐No

Are you taking birth control pills or hormonal replacement? ☐Yes ☐No

When was your last dental visit?_______________

What was the reason for your last visit?_______________

Do you have any of your x-rays or dental records?_______________

Do you like your smile?_______________

Do you wear dentures or partials? _______________

Is your mouth dry? _______________

Have you ever had any periodontal (gum) treatments? _______________

Have you ever had orthodontic (braces) treatment? _______________

Have you had any problems associated with previous dental treatment?_______________

Do you snore?_______________

Have you ever been treated for sleep apnea?_______________

How can we help you today?_______________

____

*****Are you completing this form for another person?** ☐Yes ☐No

If yes, what is your relationship to the patient:_______________

I have reviewed and understand the information on this questionnaire and certify the information I have provided is accurate and complete. I understand that this information will be used by my dental office to help determine appropriate and healthful dental treatment. If there are any changes in my medical status or condition, I will inform my dental office. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form. Since at each visit treatment plan will be presented and the work to be done is explained to me before treatment is begun, I give my dental office my consent to perform any needed dental treatment. I understand that I am financially responsible for all charges whether covered or denied by my insurance company. I also understand that, even with or without insurance coverage, I am responsible for any charges that are incurred for any treatment rendered.

_______________ Name

_______________ Relationship to Patient

_______________ Patient/Guardian Signature

_______________ Date