

Today's Date

Account #

Patient Registration

Patient's Name _____ SINGLE MARRIED DIVORCED SEPARATED WIDOWED CHILD
SOC. SEC. # _____ Birthdate _____ Sex _____

Guarantor Information (Person Responsible For Bill)

Name _____ Soc. Sec. # _____ Birthdate _____
Address _____ City _____ State _____ Zip _____
_____ Email _____
Home Phone _____ Work Phone _____ May we call you at work? _____
Employer _____
Spouses Name _____ Soc. Sec. # _____ Birthdate _____
Spouses Employer _____ Phone _____ May we call you at work? _____
In case of emergency contact _____ Phone _____ Relationship _____
Whom may we thank for referring you? _____

Dental History

What is the primary reason for your visit? _____
When was your last dental visit? _____
Have your previous dental experiences been favorable? _____ If not, please explain _____

Name of previous dentist _____
Are you interested in _____Cosmetic Dentistry _____Replacing missing teeth _____Nitrous Oxide Gas
_____Dentures _____Bleaching(Whitening) _____Tooth colored fillings

Child's History (if applicable)

Is this your child's first visit? _____ Are any teeth hurting? _____
What is your child's favorite toy or activity? _____
Does your child have any mouth habits (thumb sucking)? _____
Is your child currently receiving fluoride? _____
May we use Nitrous Oxide Gas during treatment? _____

Please indicate with a check if you have had, or have any of the following:

- | | | | |
|--|---------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Teeth sensitive to | <input type="checkbox"/> cold | <input type="checkbox"/> heat | <input type="checkbox"/> Gum recession |
| | <input type="checkbox"/> sweets | <input type="checkbox"/> pressure | <input type="checkbox"/> Periodontal (gum) treatment |
| <input type="checkbox"/> Broken Teeth | | | <input type="checkbox"/> Frequent filling replacement |
| <input type="checkbox"/> Habitual grinding or clenching of teeth | | | <input type="checkbox"/> Discolored teeth |
| <input type="checkbox"/> Jaw joint pain | | | <input type="checkbox"/> Crooked teeth |
| <input type="checkbox"/> Clicking or popping of jaw joints | | | <input type="checkbox"/> Orthodontic treatment (braces) |
| <input type="checkbox"/> Gum boils or abscesses | | | <input type="checkbox"/> Injury to face or jaws |
| <input type="checkbox"/> Does food catch between your teeth | | | <input type="checkbox"/> Root canal treatment |
| <input type="checkbox"/> Bleeding gums | | | <input type="checkbox"/> Wisdom tooth removal |

Medical History

This information will help out in preventing serious medical complications or contagious disease. Any information given will be held in the strictest of confidence and will be released only with permission.

Name of physician _____ Date of last physical _____

What medication have you taken in the last three months? _____

Are you under medication treatment? _____ If yes, please describe _____

Do you smoke or use smokeless tobacco? _____ If yes, how much? _____

Have you had a reaction to any of the following: Penicillin Erythromycin Tetracycline
 Sulfa Drugs Codeine Latex Aspirin Other _____

If you have any of the following, please check and describe below:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Recovering alcoholic |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> AIDS related complex |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> TB Tuberculosis |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Radiation treatment | WOMEN |
| <input type="checkbox"/> Needed antibiotic pre-med.
prior to dental work | <input type="checkbox"/> Cancer | Are you pregnant? _____ |
| | <input type="checkbox"/> Substance abuse | If so, how far along? _____ |

Please describe _____

Signature _____ Date _____ Witness _____

Medical Update

Any changes in your Medical History, since your last visit? _____ Date _____

Are you taking any medications? _____ WOMEN

_____ Are you pregnant? _____

_____ If so, how far along? _____

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Are you taking any medications? _____ WOMEN

_____ Are you pregnant? _____

_____ If so, how far along? _____

Any changes in your Medical History, since your last visit? _____ Date _____

Are you taking any medications? _____ WOMEN

_____ Are you pregnant? _____

_____ If so, how far along? _____