

PATIENT REGISTRATION

Welcome! So that we may provide you with the best possible care, please complete this medical/dental history form.

All information will remain completely confidential.

Patient Name: _____ Date: _____
Last First MI

Preferred Name To Be Called By: _____ Email Address: _____

Male Female Married Single Child Other _____

Social Security Number: _____ Birth Date: _____

Phone (Cell): _____ Phone (Work): _____ Phone (Home): _____

Address: _____
Street Apt. Number

City State Zip Code

Referral Information

How did you hear about our office? Another Patient: _____ Drive By _____ Internet _____
Referring Doctor: _____ Website _____ Other: _____

Previous Dentist name : _____ What is your reason for your visit today? _____

Date and reason of last dental visit: _____ Cleaning: _____

Have you ever had any of the following? Please check those that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths _____ | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Condition _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis-Type _____ | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Bleeding Disorder/Disease | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Congenital Heart Condition | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Nervous Disorders | Any Adverse Reaction: |
| <input type="checkbox"/> Cold Sores/Blisters | <input type="checkbox"/> Pacemaker | _____ |
| <input type="checkbox"/> Diabetes-Type _____ | <input type="checkbox"/> Psychiatric Care | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Open Heart Surgery _____ | _____ |

Do you, or have you, had any disease, condition, or problem not listed? _____

Are you: Pregnant? Yes, _____ months No Nursing? Yes No Birth Controls Pills? Yes No

Have you been under the care of a medical doctor during the past two years?

If yes, please explain: _____

Physician's Name: _____ Phone #: _____

Have you taken any medication or drugs during the past two years? Yes No

Are you currently taking any medication, drugs, or pills? Yes No

If yes, please list name, dosage, and reason: _____

How often do you have dental examinations: _____ How often do you brush? _____ Floss? _____

Signature of Patient, Parent, or Guardian _____ **Date:** _____

Are you satisfied with the appearance of your teeth? Yes No

Would you like to have whiter teeth? Yes No

Have you noticed any bad odor or taste in your mouth? Yes No

Are your teeth sensitive to:

Hot or Cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Do you smoke or use smokeless tobacco? Yes No

If yes, how much per day? _____

Do your gums bleed or hurt? Yes No

Have your parents experiences gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Do you frequently get cold sores, blisters, or any other oral lesions? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? _____

Have you ever had:

Orthodontic treatment (Braces)? Yes No

Oral surgery? Yes No

Periodontal treatment (Gum Surgery)? Yes No

Your teeth filed or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If yes, please describe, including the cause: _____

Have you experienced clicking or popping of the jaw? Yes No

If yes, is it ever painful? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

Have you ever had a bad dental experience? Yes No

If yes, please describe: _____

Is there anything else you would like us to know about having dental treatment? Yes No

If yes, please describe: _____

Difficulty getting numb? Yes No

Signature of Patient, Parent, or Guardian _____ Date: _____