PATIENT REGISTRATION FORM

Patient Information

Patient's First Name		Middle Initial	Last Name		Patient Type (circle one) Child Adult	
Date of Birth (MM/DD/YYYY)	Social Security Number		Sex	Marital Status	Referred by	
Patient's Street Address			City		State	Zip
Primary Phone: Home / Cell	Alternate Phone: Home / Cell		Email		Preferred Contact Method: (circle one) Phone Text Email	

Insurance and Billing

Primary Insurance Information

Insurance Company		Insurance Company Phone Number		
Plan / Policy Number	Group Number	Policy Holder's Employer		
Policy Holder's Name (as it appears on insurance card)	Policy Holder's Social Security Number		Policy Holder's Date of Birth (MM/DD/YYYY)	
Policy Holder's Street Address	City		State	Zip
Policy Holder's Phone Number	Relationship to Policy Holder			

Secondary Insurance

Insurance Company		Insurance Company Phone Number	
Plan / Policy Number	Group Number	Policy Holder's Employer	
Policy Holder's Name (as it appears on insurance card)	Policy Holder's Social Security Number		Policy Holder's Date of Birth (MM/DD/YYYY)
Policy Holder's Phone Number	Relationship to Policy Holder		

Responsible Party

Billing Name (if other than patient)		Social Security Number	Date of Birth (MM/DD/YYYY)	Relationship to Patient
Street Address		City	State	Zip
Primary Phone: Home / Cell	Alternate Phone: Home / Cell	Email	Preferred Contact Method: (circle one) Phone Text Email	

Consent and Signature

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agent embodies a certain risk. I have read, understand, and agree to the aforementioned terms and conditions.

Signature of person completing form: ______________________________

Date: ____________________

Relationship (if other than patient): ______________________________

Patient Last Name ____________________ DOB __________

Patient History

Dental History

Reason for dental visit today ______________________________

Are you experiencing any of the following?

Tooth or gum sensitivity	☐ Yes	☐ No
Headaches / Ear aches / Neck pain	☐ Yes	☐ No
Jaw pain	☐ Yes	☐ No
Grinding or clenching teeth	☐ Yes	☐ No
Teeth or fillings broken / missing	☐ Yes	☐ No
Loose / Shifting teeth	☐ Yes	☐ No
Bad breath	☐ Yes	☐ No

Do you smoke or use chewing tobacco? ☐ Yes ☐ No

If yes, how much? __________ How many years? __________

Have you had any of the following?

Dentures	☐ Yes	☐ No
Partial dentures	☐ Yes	☐ No
Braces	☐ Yes	☐ No
Periodontal (gum) treatments	☐ Yes	☐ No

Cleanings & X-Rays

Last dental cleaning ________________ month/year

Last oral cancer screening ________________ month/year

Last complete x-rays ________________ month/year

Previous Dentist Information

Name of dental practice ______________________________

City ________________________ State ________

Phone number ____________________________

Medical History

Have you ever been diagnosed with any of the following?

☐ AIDS / HIV	☐ Blood Disorder	☐ Glaucoma	☐ Kidney Disease	☐ Rheumatism	☐ Tuberculosis
☐ Anemia	☐ Cancer	☐ Heart Murmur	☐ Liver Disease	☐ Scarlet Fever	☐ Ulcers
☐ Arthritis	☐ Diabetes	☐ Hepatitis A, B, or C	☐ Mitral Valve Prolapse	☐ Seizures	☐ Venereal Disease
☐ Asthma	☐ Emphysema	☐ High Blood Pressure	☐ Respiratory Problems	☐ Stroke	☐ Other
☐ Auto Immune Disorder	☐ Epilepsy	☐ HPV	☐ Rheumatic Fever	☐ Thyroid Disease	________________

Do you have any of the following conditions?

- ☐ Anxiety / Depression
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Jaundice
- ☐ Sinus Problems

Do you have any of the following?

- ☐ Artificial Joint
- ☐ Artificial Heart Valve
- ☐ Pacemaker

Are you allergic to or have you reacted adversely to any of the following medications / items?

☐ Aspirin	☐ Darvon	☐ Latex	☐ Nitrous Oxide	☐ Percodan	☐ Tetracycline
☐ Codeine	☐ Erythromycin	☐ Local Anesthetic	☐ Penicillin	☐ Sulfa	☐ Valium
☐ Other					

Have you ever taken any of the following medications?

- ☐ Actonel
- ☐ Aredia
- ☐ Boniva
- ☐ Fosamax
- ☐ Herbal Supplements
- ☐ Reclast
- ☐ Zometa

Are you currently taking cortisone medication? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No

Are you currently under a physician's care? ☐ Yes ☐ No

If yes, list reason		
Physician Name	Physician Phone	List of Current Medications