Thank You for Selecting Our Dental Team

PATIENT REGISTRATION

Name: _____ Date of Birth _____ Home Phone _____
Last First Initial

Email _____ Cell Phone _____

Address _____ Town _____ Zip _____

Social Security # _____ Marital Status _____ Sex _____

Occupation _____ Employed By _____

Business Phone _____ Dental Insurance Co. _____ Group # _____

Spouse's Name or Guardian if Patient is a Minor _____ Social Security # _____

Occupation _____ Employed By _____

Business Phone _____ Dental Insurance Co. _____ Group # _____

Whom May We Thank for Referring You to Our Office _____

GENERAL HEALTH HISTORY

Physician's Name and Address: _____ Phone No. _____

Name of Any Medication Now Taking, and for What Reason: _____

_____

Serious Illness or Operation, What Was It and When: _____

_____

Please Circle Any Illness You Have Had, and When:

Heart Attack
Angina, Chest Pains
Abnormal Blood Pressure
Stroke
Irregular Heartbeat, Pacemaker
Prosthetic Heart Valves
Congenital Heart Lesions
Rheumatic Fever
Heart Murmur
Other Heart Disease
Bleeding Problems
Smoker/Tobacco Use

Drug Abuse, /Alcoholism
Fainting Spells
Lung Disease,Tuberculosis, Persistent Cough
Shortness of Breath
Swelling of Ankles
Allergies
Skin Rash
Hepatitis, Jaundice
Liver Disease
Kidney Disease
Nervous Disorders
HIV/A.I.D.S.

Anorexia, Bulemia
Epilepsy, Seizures
Asthma
Anemia
Cancer, Tumors
Radiation Treatments, Chemotherapy
Thyroid Problems
Stomach or Intestinal Problems
Arthritis, Rheumatism
Diabetes
Venereal Disease
Oral Herpes, Ulcerations
Osteoporosis

Other _____

Have You Ever Had a Bad Reaction to:

Penicillin ☐ Codeine ☐ Aspirin ☐ Anesthetics ☐ Other _____

Are You Pregnant? (Women) _____ No. of Months _____

DENTAL HEALTH HISTORY

How Long Since Last Dental Exam? _____

If You Could Change Something About Your Smile, What Would It Be: _____

Please Circle Any You Have Noticed:

Toothache
Teeth Tender to Chew On
Bleeding Gums
Bad Breath or Taste
Spaces Developing or Food Catching Between Teeth

Cracked or Lost Fillings
Change in Color of Teeth or Gums
Ulcers
Swelling or Lump in Mouth
Teeth Sensitive to Hot, Cold, Sweets

Payment is expected when services are rendered unless other arrangements are made in advance.

_____ _____
DATE SIGNATURE

FORM 170735 R/15/15 ITEM 8101