



Adult Patient Registration & Patient Medical History

Name _____ Gender _____
Last First MI Male Female

Marital Status Single Married Divorced Widowed Domestic Partner Birthdate _____

Address _____
Street City State Zip

Email _____
Please Print

Cell # _____ Work # _____ Ext. _____

Home # _____

Employer _____ Occupation _____

Spouse / Additional Contact Information

Name _____ Birthdate _____
Last First

Same Address

Address _____
Street City State Zip

Email _____
Please Print

Cell # _____ Work # _____ Ext. _____

Home # _____

Employer _____ Occupation _____

Primary DENTAL Insurance

Policy Owner Name _____ Policy Owner Soc. Sec # _____

Policy Owner Birthdate _____ Relationship to Patient _____

Policy Owner Employer _____ Insurance Company _____

Group ID # _____ Insurance Phone # _____

Secondary DENTAL Insurance (if applicable)

Policy Owner Name _____ Policy Owner Soc. Sec # _____

Group ID # _____

Insurance Phone # _____

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Dental History

Reason for seeking dental care at this time? _____

Date of last dental visit? _____ Reason? _____

Former Dentist or current DDS if visiting? _____ City / ST _____

How often do you brush? Once a day Twice a day Three times a day

How often do you floss? 1 2 3 Day Week Month

How do you feel about dental treatment? Relaxed Uneasy Anxious Tense

Have you ever had Nitrous Oxide (laughing gas) during dental treatment? No Yes

Have you ever been requested to take antibiotics or other medications before a dental appointment? No Yes

Do you have, or have you ever had any of the following?

- | | |
|--|---|
| <input type="radio"/> Aching/Sensitive Teeth | <input type="radio"/> Difficulty Opening |
| <input type="radio"/> Bleeding Gums | <input type="radio"/> Gum Infection |
| <input type="radio"/> Grinding/Clinching | <input type="radio"/> Oral Surgery |
| <input type="radio"/> Cold Sores | <input type="radio"/> Clicking/Popping Jaw |
| <input type="radio"/> Broken Filling | <input type="radio"/> Jaw Pain |
| <input type="radio"/> Loose Teeth | <input type="radio"/> Orthodontics |
| <input type="radio"/> Bad Breath | <input type="radio"/> Periodontal Treatment |
| <input type="radio"/> Dry Mouth | <input type="radio"/> None |
| <input type="radio"/> Areas of Food Traps | |

Check if you could change any of the following about your smile:

- | | |
|---|---|
| <input type="radio"/> Close gaps between teeth | <input type="radio"/> Replace missing teeth |
| <input type="radio"/> Straighten/even out front teeth | <input type="radio"/> None |
| <input type="radio"/> Whiten teeth | <input type="radio"/> Other |
| <input type="radio"/> Change shape of teeth | |

Please explain

I would be interested in the Doctor giving me an overall comprehensive long term plan for restoring my smile?

- Yes No

Medical History

Physician's Name _____

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

If so for what reason? _____

Check the conditions to indicate if you have or have had any of the:

- | | | |
|--|---|---|
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> HIV or AIDS | <input type="radio"/> Diabetes |
| <input type="radio"/> Heart Disease | <input type="radio"/> Herpes | <input type="radio"/> Epilepsy or Seizures |
| <input type="radio"/> Heart Murmur | <input type="radio"/> High Blood Pressure | <input type="radio"/> Fainting/Dizzy Spells |
| <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Stroke | <input type="radio"/> Psychiatric Treatment |
| <input type="radio"/> Pacemaker | <input type="radio"/> Cancer | <input type="radio"/> Chemical Dependency |
| <input type="radio"/> Heart Surgery | <input type="radio"/> Chemotherapy | <input type="radio"/> Bleeding Problems |

- Rheumatic/Scarlet Fever
- Artificial Joint
- Hepatitis A, B, C
- Liver Disease
- Kidney Disease
- Radiation Therapy
- Glaucoma
- Asthma
- Sinus Trouble
- Tuberculosis
- Circulatory Problems
- Headaches
- Back Problems
- None of the above

Continued on next page...

Medical History Continued

Women only, check if you are: Pregnant Nursing Birth Control

Please list drugs, medications or injections taken in the last 3 months:

List Allergies: Aspirin Latex Sulfa
 Codeine Penicillin No

List any other allergies:

Have you ever taken Fen-Phen? Yes No

Do you use cigarettes and/or tobacco? Yes No

Do you use or do you have a history of using illegal drugs? Yes No

How often do you consume alcohol? Never Occasionally Weekly Daily

Would you like to speak to the Doctor privately about any concerns? Yes No

How did you hear about our office Google (Reviews) Yelp (Reviews) Media Ad

Other _____

Friend/Family/Patient _____

I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand financial arrangements must be made in advance. I am personally responsible for payment of all fees for dental services in this office regardless of insurance coverage. Payment is due when services are rendered. All emergency services or any dental service performed without prior financial arrangements must be paid for at the time services are performed.

Acceptance of Terms

I have read and accept the above conditions

Patient Signature

Date

Doctor Signature

Date