



Patient Registration

Please complete all blanks. Place N/A if question is not applicable. Date _____

Patient Information

Legal Name _____ Preferred Name _____

Home Address _____ Home Phone _____

City, State, Zip _____ e-mail _____

Employer _____ Work Phone _____

Occupation _____ Pager/Cell Phone _____

SSN# _____

DOB _____

Male _____ Female _____

Married _____ Single _____ Divorced _____ Widowed _____

List any other family members that are patients _____

How did you hear about us? _____

Legal Guardian (if under 18)

Insured Party Information

Legal Name _____ Preferred Name _____

Home Address _____ Home Phone _____

City, State, Zip _____ e-mail _____

Employer _____ Work Phone _____

SSN# _____ Pager/Cell Phone _____

DOB _____

Male _____ Female _____

Primary Insurance Company

Please have your card available for our records at every visit.

Company _____ Group # _____

Policy # _____ Insurance Phone _____

Address _____

What is your immediate dental concern? _____

How long since your last visit? _____

Medical & Dental History

Personal Physician _____ Phone _____

List any and all medications you are currently taking _____

List any and all allergies (drug and material) _____

Emergency Contact _____ Phone _____

Do any of the following conditions apply to you:

Heart Disease / Heart Surgery	YES	NO	Cancer	YES	NO
Heart Murmur / Mitral Valve Prolapse	YES	NO	HIV Positive, AIDS	YES	NO
Heart Attack	YES	NO	Artificial Joints	YES	NO
Rheumatic Fever	YES	NO	Venereal Disease	YES	NO
High or Low Blood Pressure	YES	NO	Use of Redux or Fen-Phen	YES	NO
Blood Disease	YES	NO	Metal Allergies	YES	NO
Blood Transfusion	YES	NO	Allergic to Latex	YES	NO
Bleeding Problems	YES	NO	Use Tobacco Products	YES	NO
Hepatitis, Jaundice	YES	NO	what type		
Diabetes	YES	NO	Is Halitosis (Bad Breath) a concern	YES	NO
Fainting Spells, Seizures	YES	NO	Mouth Ulcers, Fever Blisters	YES	NO
Severe Headaches	YES	NO	Bleeding Gums	YES	NO
Tuberculosis, Respiratory Problems	YES	NO	Are you pregnant or nursing	YES	NO
			Are you planning a pregnancy in the near future?	YES	NO

ANY OTHER MEDICAL PROBLEMS/CONDITIONS NOT LISTED ABOVE: _____

Have you had:

An unhappy or problem dental experience? YES NO

Any orthodontic (braces) or periodontal (gum) treatment before? YES NO

Have you noticed:

Pain or soreness in either jaw joint? YES NO

Popping, clicking or grating in either jaw joint? YES NO

Chronic or tension headaches related to your teeth or bite? YES NO

When you smile:

Do you like the brightness of your teeth? YES NO

Do you like the color of your teeth? YES NO

Do you like the shape of your teeth? YES NO

Do you like the alignment of your teeth? YES NO

Do you have fillings that show? YES NO

If you could change anything about your smile, what would it be? _____

Signature

Printed Name

Date