Dental Registration and History

Date_____

Patient Name: _____ _____

Last Name First Name Middle Initial

SSN: _____ Birth date: _____

Sex: Male _____ Female _____

Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip code: _____

Email: _____

Home # _____ Work # _____ Cell # _____

Other # _____ Email: _____

Would you like to receive appointment confirmation texts and emails?

Please Circle: Minor Single Married Partnered Separated Divorced Widowed

Responsible Party's Name: _____

Patient Employer/School: _____

Employer/School Address: _____

Occupation: _____

Spouse's Name: _____

Spouse's Date of Birth: _____

Spouse's Employer: _____

Who may we thank for referring you? _____

In Case Of Emergency: Please give two contact names

Name: _____ Relationship to you: _____

Cell # _____ Home or Work # _____

Name: _____ Relationship to you: _____

Cell # _____ Home or Work # _____

Dental Insurance:

Subscriber name if different from patient: _____

Birthdate: _____ SSN# _____ Relationship to patient: _____

Employer Name: _____

Insurance Co. Name & Phone # _____

Insurance Co. Address: _____

Group #_____ ID#_____

Is patient covered by additional insurance? Yes No

Subscriber's Name: _____

Birthdate: _____ SSN# _____ Relationship to patient _____

Employer Name: _____

Insurance Co. Name & Phone # _____

Insurance Co. Address _____

Group #_____ ID#_____

Dental History

Reason for today's visit: _____
Former Dentist: _____
Address: _____ Phone #_____
Date of last dental visit: _____
Date of last x-rays: _____

Please place an X to indicate if you

- ___ Bad breath
- ___ Bleeding gums
- ___ Blisters on lips or mouth
- ___ Burning sensation on tongue
- ___ Chew on one side of mouth
- ___ Chewing tobacco
- ___ Cigarette, pipe, or cigar smoking
- ___ Clicking or popping of jaw
- ___ Dry mouth
- ___ Fingernail biting
- ___ Orthodontic treatment
- ___ Periodontal treatment
- ___ Sensitivity to cold
- ___ Sensitivity to heat
- ___ Sensitivity to sweets
- ___ Food collection between teeth
- ___ Sores or growths in mouth
- ___ Grinding teeth
- ___ Gums swollen or tender
- ___ Jaw pain or tiredness
- ___ Lip or cheek biting
- ___ Loose teeth or broken fillings
- ___ Mouth breathing
- ___ Pain around ear

Health History

- ___ AIDS/HIV
- ___ Anemia
- ___ Arthritis, Rheumatism
- ___ Artificial Heart Valves
- ___ Artificial Joints
- ___ Asthma
- ___ Back Problems
- ___ Bleeding (w/ extractions or surgery)
- ___ Blood Disease
- ___ Cancer
- ___ Chemical Dependency
- ___ Chemotherapy
- ___ Cortisone Treatments
- ___ Cough, persistent or bloody
- ___ Diabetes
- ___ Emphysema
- ___ Epilepsy
- ___ Fainting or Dizziness
- ___ Glaucoma
- ___ Headaches
- ___ Heart Murmur
- ___ Heart Problems
- ___ Hepatitis Type ____
- ___ Herpes
- ___ High Blood Pressure
- ___ Jaundice
- ___ Jaw Pain
- ___ Kidney Disease
- ___ Liver Disease
- ___ Low Blood Pressure
- ___ Mitral Valve Prolapse
- ___ Nervous Problems
- ___ Pacemaker
- ___ Psychiatric Care
- ___ Radiation Treatments
- ___ Respiratory Disease
- ___ Rheumatic Fever
- ___ Shortness of Breath
- ___ Sinus Trouble
- ___ Skin Rash
- ___ Special Diet
- ___ Stroke
- ___ Swollen Feet or Ankles
- ___ Swollen Neck Glands
- ___ Thyroid Problems
- ___ Tonsillitis
- ___ Tuberculosis
- ___ Tumor or growth on head/neck
- ___ Ulcer
- ___ Venereal Disease
- ___ Weight loss, unexplained

Physician Name & Number _____
Pharmacy Name & Number _____
Medications_____
_____
Allergies _____
_____