Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)

Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Referred by		

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone

Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Dental Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Insured's Address	City	State	Zip

Insured's Social Security Number	Insured's Birthdate	

Secondary Dental Insurance

Insurance Company	Plan

Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number

Insured's Name (as it appears on insurance card or ID)	Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

_____ _____

Signature of Patient or Authorized Guardian Date

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

_____

_____

_____

_____

_____

Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name _____ Reaction _____

Name _____ Reaction _____

Hospitalizations & Surgeries

Reason _____ Date _____

Reason _____ Date _____

Reason _____ Date _____

Dental History

When was your last dental exam?

Date _____

When were your last dental x-rays taken?

Date _____

How often do you brush?

times/day _____

How often do you floss?

times/day _____

Do you grind your teeth?

☐ Yes ☐ No

Have you ever had orthodontic (braces) treatment?

☐ Yes ☐ No

Have you ever had periodontal (gum) treatments?

☐ Yes ☐ No

Do you have any of the following?

☐ Bad Breath ☐ Dry Mouth ☐ Partials
☐ Bleeding Gums ☐ Difficulty Chewing ☐ Sensitivity to Cold
☐ Blisters on Mouth ☐ Ear Pain ☐ Sensitivity to Heat
☐ Broken Fillings ☐ Jaw Pain ☐ Sensitivity to Sweets
☐ Clicking Jaw ☐ Loose Teeth ☐ Sensitivity to Pressure
☐ Dentures ☐ Mouth Pain ☐ Swollen Gums
☐ Difficulty Opening or Closing ☐ Mouth Sores

Past Medical History

Have you ever had any of the following?

☐ Alcoholism ☐ Bleeding Disorder ☐ Eating Disorder
☐ Allergies ☐ Blood Disease ☐ Epilepsy
☐ Anemia ☐ Blood Transfusion ☐ Hay Fever
☐ Anxiety Disorder ☐ Bowel Disorder ☐ Heart Disease
☐ Arthritis ☐ Cancer ☐ Heart Problems
☐ Asthma ☐ Diabetes ☐ Hepatitis - A, B, or C
☐ AIDS / HIV ☐ Depression ☐ High Blood Pressure
☐ High Cholesterol ☐ Migraines ☐ Stomach Ulcer
☐ Joint Disorder ☐ Osteoporosis ☐ Substance Abuse
☐ Kidney Disorder ☐ Pacemaker ☐ Thyroid Disorder
☐ Liver Disorder ☐ Rheumatic Fever ☐ Tuberculosis
☐ Lung Disease ☐ Sinus Problems ☐ Venereal Disease
☐ Lupus ☐ Skin Disorder
☐ Measles ☐ Stroke

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

Women Only

Are you pregnant?

☐ Yes ☐ No

Are you breastfeeding?

☐ Yes ☐ No

What is your method of birth control?

_____