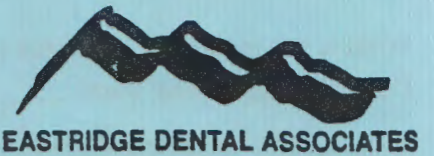


**PATIENT REGISTRATION**

Please complete the following confidential information and sign both front & back.



**Patient Information**

Date \_\_\_\_\_

Patient's Legal Name last \_\_\_\_\_ first \_\_\_\_\_ m.i. \_\_\_\_\_

By what name do you wish to be called? \_\_\_\_\_

Residence street \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Children \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Is another member of your family or relative a patient at our office? name \_\_\_\_\_ relation \_\_\_\_\_

How did you hear of our office \_\_\_\_\_

**Responsible Party Information**

Name last \_\_\_\_\_ first \_\_\_\_\_ m.i. \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Residence street \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (if less than 3 yrs.) street \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Date Employed \_\_\_\_\_

Spouse's Name last \_\_\_\_\_ first \_\_\_\_\_ m.i. \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Date Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

**Insurance Information**

**Dental Insurance Company**

Address street \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employee Social Security # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Group Number \_\_\_\_\_

**Secondary Insurance Company**

Address street \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employee Social Security # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Group Number \_\_\_\_\_

I, the undersigned (patient or legally responsible party) authorize treatment to be rendered by the dentist and is staff, and assume full financial responsibility, I authorize the release of any information necessary for the filing of insurance claims and hereby authorize payment directly to the dentist for benefits payable to me by the insurance company or administrator. I understand where appropriate, credit bureau reports may be obtained. This is valid until written notification from me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Dental History

What is the reason for your visit today? \_\_\_\_\_

Date of....Last Dental Visit? \_\_\_\_\_ Last Dental Cleaning? \_\_\_\_\_

Last Full Mouth X-rays? \_\_\_\_\_ Previous Dentist's name \_\_\_\_\_

Do you have any dental problems now? \_\_\_\_\_

Have you ever had.....please circle all that apply

Periodontal Treatment

Oral Surgery

Orthodontic Treatment

Injury to the mouth or head

Jaw joint noises, clicking

Mouth odors or bad tastes

Sores or lesions

Bleeding gums

Sensitive teeth

TMJ Treatment

Dizziness

Ear pain

Jaw pain

Neck pain

Snoring

Are you satisfied with your teeth's appearance? \_\_\_\_\_

Have you ever had an upsetting dental experience? \_\_\_\_\_

Are you interested in any specific dental treatment? Cosmetic? \_\_\_\_\_ Orthodontic? \_\_\_\_\_

Other? \_\_\_\_\_

### Health History

Physician's Name \_\_\_\_\_ Date of your last visit \_\_\_\_\_

Are you under care now? \_\_\_\_\_ For what reason? \_\_\_\_\_

Have you had any illnesses, operations, or accidents? \_\_\_\_\_

Have you been hospitalized for any reason? \_\_\_\_\_

Have you ever had any of the following?.....please circle all that apply

Heart disease/surgery

Congenital Heart Problem

Heart Murmur

High Blood Pressure

Low Blood Pressure

Rheumatic fever

HIV or Aids

Latex Sensitivity

Psychiatric Treatment

Kidney trouble

Stomach ulcers

Venereal disease

Diabetes

Asthma

Emphysema

Glaucoma

Chemical dependency

Stroke

Anemia

Fainting

Jaundice

Cancer

Radiation Therapy

Hepatitis

Epileptic seizures

Headaches

Food Allergys

Tuberculosis

Sinus/Ear Problems

Artificial Joints

Are you allergic to penicillin? \_\_\_\_\_ or anything else? \_\_\_\_\_

Have you had any adverse reaction to any drug or medication? \_\_\_\_\_

Are you taking any aspirin? \_\_\_\_\_ vitamins? \_\_\_\_\_ Birth control pills? \_\_\_\_\_

Are you taking any medications, prescription or non-prescription? \_\_\_\_\_

Please list them and the reasons you are taking them \_\_\_\_\_

Have you had any excessive bleeding with minor cuts, surgery, or extractions? \_\_\_\_\_

Explain? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_