PATIENT REGISTRATION AND HISTORY

PATIENT INFORMATION

Date____

Name____
LAST FIRST MI

Preferred Name______________________________

Sex: M ☐ F ☐ Marital Status: Single ☐ Married ☐

Date of Birth_______________________________

Social Security Number______________________

Address_____________________________________

City____________________State_____Zip_________

Home Phone ( )______________________________

Work Phone ( )______________________________

Cell Phone ( )______________________________

Best daytime contact number: H ☐ W ☐ C ☐

Occupation__________________________________

Employer____________________________________

City____________________State_____Zip_________

DENTAL INSURANCE

Primary Insurance

Insurance Co.________________________________

Subscriber Name_____________________________

Subscriber SS# or ID#________________________

Subscriber Date of Birth_____________________

DENTAL HISTORY

Previous Dentist:____________________________

Date of Last Dental Visit: ___________________

Reason for Last Dental

Visit:______________________________

Are you currently having pain in your mouth?______________

If yes, where is your pain located?

☐ Upper Right ☐ Upper Left ☐ Lower Left ☐ Lower Right

Check all that apply

☐ Smoking ☐ Jaw Pain ☐ Dry Mouth

Are you satisfied with the appearance of your teeth? Yes ☐ No ☐

If no, what would you like to change?

____

____

Who can we thank for referring you?

MEDICAL HISTORY

Physician's Name____________________________

City / State________________________________

Check all that apply:

YES	NO		YES	NO	
☐	☐	AIDS / HIV	☐	☐	High blood pressure
☐	☐	Arthritis	☐	☐	Kidney disease
☐	☐	Artificial Heart Valves	☐	☐	Liver disease
☐	☐	Asthma	☐	☐	Low blood pressure
☐	☐	Bleeding problems	☐	☐	Nervous problems
☐	☐	Blood disease	☐	☐	Pacemaker
☐	☐	Cancer	☐	☐	Psychiatric care
☐	☐	Diabetes	☐	☐	Radiation
☐	☐	Epilepsy	☐	☐	Respiratory problems
☐	☐	Fainting/dizziness	☐	☐	Stroke
☐	☐	Heart Problems	☐	☐	Sinus trouble
☐	☐	Hepatitis type______	☐	☐	Thyroid problems

List any other medical problems:______________

____

Medications

List prescription medications you are currently taking:

____

____

____

____

____

____

____

____

____

____

Allergies:

Codeine ☐ Penicillin / Amoxicillin ☐

Hydrocodone ☐ Latex ☐

Local anesthetic ☐ Other ☐ ______________

Women

Are you pregnant? Yes ☐ No ☐ Due Date_____________

Nursing? Yes ☐ No ☐

Emergency Contact:

Name____

Relationship________________________________

Phone #( )__________________________________

Office Use Only

BP = ____________________ P =_______________