WELCOME TO OUR OFFICE

Patient Registration

Date _____

Patient Name_____ Nickname _____ Sex _____
Address _____ SS# _____ Birthday _____
City _____ State __ Zip _____ Home Phone _____ Cell Phone _____
E-mail _____

Employer _____ Address _____
Work Phone _____ Position _____
Spouse's Name _____ SS# _____ Employer _____

Person Responsible For This Account If Other Than The Patient

Responsible Parties Name _____ Relationship to Patient _____
Address _____ Home Phone_____
Employer _____ Work Phone _____
E-Mail _____ Cell Phone _____
Whom may we thank for referring you? _____
Do you have Dental Insurance? (Y N) _____
In case of emergency who should we contact? _____ Phone_____

Other Family Members:

NAME	AGE	NAME	AGE
_____	____	_____	____
_____	____	_____	____
_____	____	_____	____
_____	____	_____	____

ADULT MEDICAL HISTORY

Name _____

What would you like us to do for you today ?_____
Is your General Health ...(Excellent, Good ,Fair, Poor) ?_____
Are you under the care of a Physician at this time ? (Y,N) For What?_____
Name and Address of Physician _____
Date of last physicial examination _____
Please list all medications now taken_____

PLEASE CHECK ANY CONDITIONS YOU HAVE HAD.

Rheumatic Fever ___ , Asthma ___ , Radiation Treatments ___ , HIV ___ , Heart Problems ___ ,
Lung Disease ___ , Abnormal Blood Pressure ___ , Heart Murmur ___ , Epilepsy ___ ,
Circulatory Problems ___ , Hepatitis ___ , Stroke ___ , Jaundice ___ , Cancer ___ ,
Anemia ___ , Kidney Disease ___

Are you subject to prolonged bleeding? Y N
Are you subject to fainting? Y N
Are you allergic to any medications? Y N List _____
Do you have an artificial joint or heart valve? Y N
WOMAN: Are you or could you be pregnant? Y N
Do you take birth control medication? Y N

DENTAL HISTORY

Date of your last dental visit_____ For what?_____
Name of your previous/current Dentist_____
Are you satisfied with the appearance of your teeth? Y N explain_____
Do you feel that you have bad breath or a bad taste in your mouth? Y N
Does your jaw joint click or pop? Y N Is it painful? Y N
Do your gums bleed? Y N when _____
Have you ever had gum disease or pyorrhea? Y N
Are your teeth sensitive to . . . Hot? Cold ? Pressure? Sweets?
Have you had orthodontic treatment? Y N
DO YOU: Chew gum? ....., Use a soft tooth brush ..... , Use mouth wash ..... ,
Use floss? ....., Chew tobacco ..... , Smoke? ..... ,

Have you had an unpleasent experience in a dental office? explain _____
How can we make you feel more at home?_____
Is there anything else we should know about your medical and dental history?_____

_____

PATIENTS SIGNATURE _____ DATE _____