REGISTRATION FORM

PATIENT INFORMATION

First Name: _____ Last Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Personal Phone: _____ Work Phone: _____ Insurance Plan: _____

How did you hear about us (Online, Insurance, Friend, Advertisement)? _____ Patient is: ☐ Policy Holder ☐ Responsible Party

Why are you coming in today? _____ When was your last dental exam and x-rays? _____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

First Name: _____ Last Name: _____ DoB: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Responsible Party is: ☐ Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

ALLERGIES: ARE YOU ALLERGIC, OR HAVE YOU HAD A REACTION TO…

Local Anesthetics	☐ Yes ☐ No ☐DK	Metals	☐ Yes ☐ No ☐DK
Aspirin	☐ Yes ☐ No ☐DK	Latex (rubber)	☐ Yes ☐ No ☐DK
Codeine, narcotics	☐ Yes ☐ No ☐DK	Iodine	☐ Yes ☐ No ☐DK
Barbiturate, sleeping pills, sedatives	☐ Yes ☐ No ☐DK	Hay Fever or Seasonal Allergies	☐ Yes ☐ No ☐DK
Sulfa drugs	☐ Yes ☐ No ☐DK	Food / Animals	☐ Yes ☐ No ☐DK
Penicillin (or other Antibiotics)	☐ Yes ☐ No ☐DK	Other (specify) _____	☐ Yes ☐ No ☐DK

MEDICAL INFORMATION

Physician Name & Phone #: _____

Emergency Contact & Phone #: _____

Any disease, condition or problem we should know about? _____

Any prescription or other medications, or drugs (illicit substances): _____

Has your doctor asked you take antibiotics prior to dental treatment? _____

Serious Medical Conditions in last 5 years (hospitalization, sickness, operation, incl. any joint or heart issues)?: _____

MEDICAL CONDITIONS: HAVE YOU EVER HAD ANY OF THESE CONDITIONS (MARK "X" WHERE APPROPRIATE)…

Artificial/prosthetic heart valve	☐ Yes ☐ No ☐DK	Recurrent infections (specify)	☐ Yes ☐ No ☐DK	Previous infective endocarditis	☐ Yes ☐ No ☐DK	Damaged valves in transplanted heart	☐ Yes ☐ No ☐DK
Congenital heart disease (CHD)	☐ Yes ☐ No ☐DK	Unrepaired, cyanotic CHD	☐ Yes ☐ No ☐DK	Repaired CHD in last 6 months	☐ Yes ☐ No ☐DK	Repaired CHD with residual defects	☐ Yes ☐ No ☐DK
Heart Disease	☐ Yes ☐ No ☐DK	Heart Attack	☐ Yes ☐ No ☐DK	Hemophilia	☐ Yes ☐ No ☐DK	HIV/AIDS	☐ Yes ☐ No ☐DK
Angina	☐ Yes ☐ No ☐DK	Heart Murmur	☐ Yes ☐ No ☐DK	Arthritis	☐ Yes ☐ No ☐DK	Asthma	☐ Yes ☐ No ☐DK
Arteriosclerosis	☐ Yes ☐ No ☐DK	Pacemaker	☐ Yes ☐ No ☐DK	Anemia	☐ Yes ☐ No ☐DK	Bronchitis	☐ Yes ☐ No ☐DK
Congestive Heart Failure	☐ Yes ☐ No ☐DK	Mitral Valve Prolapse	☐ Yes ☐ No ☐DK	Blood Transfusion (date: _____)	☐ Yes ☐ No ☐DK	Abnormal Bleeding	☐ Yes ☐ No ☐DK
Damaged Heart Valves	☐ Yes ☐ No ☐DK	Low or High Blood Pressure	☐ Yes ☐ No ☐DK	Rheumatic Fever or Heart Disease	☐ Yes ☐ No ☐DK	Autoimmune disease	☐ Yes ☐ No ☐DK
Emphysema	☐ Yes ☐ No ☐DK	Sinus trouble	☐ Yes ☐ No ☐DK	Tuberculosis	☐ Yes ☐ No ☐DK	Chronic Pain	☐ Yes ☐ No ☐DK
Cancer/Chemo/ Radiation patient	☐ Yes ☐ No ☐DK	Chest pain upon exertion	☐ Yes ☐ No ☐DK	Systemic lupus erythematosus	☐ Yes ☐ No ☐DK	Gastrointestinal disease	☐ Yes ☐ No ☐DK
Diabetes (I or II)	☐ Yes ☐ No ☐DK	Malnutrition	☐ Yes ☐ No ☐DK	Ulcers	☐ Yes ☐ No ☐DK	Thyroid Problems	☐ Yes ☐ No ☐DK
Swollen neck glands	☐ Yes ☐ No ☐DK	G.E. Reflux/ Heartburn	☐ Yes ☐ No ☐DK	Hepatitis, liver disease, jaundice	☐ Yes ☐ No ☐DK	Fainting spells or seizures	☐ Yes ☐ No ☐DK
Stroke	☐ Yes ☐ No ☐DK	Glaucoma	☐ Yes ☐ No ☐DK	Epilepsy	☐ Yes ☐ No ☐DK	Sleep disorder	☐ Yes ☐ No ☐DK
Kidney Problems	☐ Yes ☐ No ☐DK	Night Sweats	☐ Yes ☐ No ☐DK	Osteoporosis	☐ Yes ☐ No ☐DK	Eating Disorders	☐ Yes ☐ No ☐DK
Severe headache/ migraines	☐ Yes ☐ No ☐DK	Severe or Rapid Weight Loss	☐ Yes ☐ No ☐DK	Sexually Transmitted Disease	☐ Yes ☐ No ☐DK	Excessive urination	☐ Yes ☒ No ☐DK
Neurological Disorders (specify)	☐ Yes ☐ No ☐DK	Mental Health Disorder (specify)	☐ Yes ☐ No ☐DK	SPECIFY ANY CONDITION:			

DENTAL CONDITIONS (SPECIFY IN DETAIL IF ANYTHING APPLIES)

Do your gums bleed? _____ Is your mouth dry? _____	Are your teeth sensitive to hot, cold, sweet, or pressure? _____	Have you ever had braces or gum treatments? _____	Do you have dental pain/ discomfort? _____	Do you wear dentures? _____ Do you have mouth sores/ ulcers? _____	Have you had problems with previous dental treatment? _____	Have you suffered a head/mouth injury? _____ Do you grind your teeth? _____	Do you have ear or neck pain? _____ Clicking or jaw discomfort? _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the practice. I understand that I am financially responsible for any balance. I also authorize the dental practice, dentist, or insurance company to release any information required to process my claims.

Patient or Guardian Signature: _____ Date: _____