PATIENT REGISTRATION

First Name:______________________________ Last Name______________________________________

Preferred Name or nickname:_______________________Sex:___M ___F Date of Birth:______________

Address:_______________________________________City____________________________ZIP___________

Mailing Address (if different from physical address):

Address:_______________________________________City__________________ZIP____________________

Home Phone:__________________Cell Phone_________________Email______________________________

General Dentist:________________________Preferred Pharmacy__________________________________

Responsible Party (if someone other than patient)

First Name:__________________________ Last Name__________________________________

Date of Birth:_______________ Home Phone:________________Cell Phone_________________

Address:_______________________________________City__________________ZIP___________

Primary Insurance Information

Name of Insured:___________________________Date of Birth_______________SS#____________________

Relationship to Patient:___Self ____Spouse ____Parent or Guardian

Employer:_______________________________Address:____

Insurance Co.:_________________________________

Address:____

Secondary Insurance Information

Name of Insured:____________________________Date of Birth___________SS#________________________

Relationship to Patient:___Self ____Spouse ____Parent or Guardian

Employer:______________________________Address:____

Insurance Co.:_________________________________

Address:____

Name____ **Date**___________________

DENTAL HISTORY

Please check all that apply

The tooth or area I am concerned with is____

- ○ I have pain now
- ○ I had pain which resolved
- ○ I never had any pain

- ○ I have had recent treatment on this tooth. When?____
- ○ I have had an accident involving this tooth
- ○ I have had many fillings on this tooth
- ○ I have had root canal treatment on this tooth. When?____
- ○ The tooth was filled or crowned. When?____
- ○ My dentist is planning to replace the present crown or bridge

If you have pain today:

When did you first notice the pain?___________________________

- ○ The pain is steady
- ○ The pain comes and goes by itself
- ○ The pain is getting worse
- ○ The pain is decreasing
- ○ The pain comes on its own
- ○ The pain is increased with eating and chewing
- ○ The pain has localized on one tooth
- ○ The pain keeps me from sleeping at night
- ○ The pain is increased by cold
- ○ The pain is increased by heat
- ○ Cold drinks and ice relieves the pain

- ○ The tooth feels elongated and sore to touch
- ○ The gum and jaw are painful
- ○ The pain spreads to my ear
- ○ The pain spreads to my eye
- ○ The whole side of my face if painful
- ○ My mouth opening is restricted
- ○ I have swelling
- ○ I have a gum blister or boil
- ○ I had swelling in the past which resolved
- ○ The tooth feels loose

- ○ I am taking antibiotics
- ○ I am taking pain medication

Other____
____
____
____
____
____

CONFIDENTIAL HEALTH HISTORY

Date____________Patient Name:_____________________________ Date of Birth:_________________

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes /No Is your general health good? If NO, explain:______________________________
____

2. Yes /No Has there been a significant change in your health within the last year? If YES, explain:
____

3. Yes /No Have you gone to the hospital or emergency room or had a serious illness in the last three years? If YES, explain:____

4. Yes /No Are you being treated by a physician now? If YES, explain:
____

5. Yes/No Are you required to pre-medicate with antibiotics prior to all dental appointments?

II. ARE YOU EXPERIENCING ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Dry mouth	Yes / No	Fever
Yes / No	Difficulty swallowing	Yes / No	Persistent cough	Yes / No	Headaches
Yes / No	Bruise easily	Yes / No	Sinus problems	Yes/No	Bleeding Problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
Yes / No	Heart attack	Yes / No	Thyroid disease	Yes / No	Artificial joint

If YES, date_________________________

Yes / No	Diabetes	Yes / No	Asthma	Yes / No	Stomach problems/ulcers
Yes / No	Diabetes	Yes / No	Hepatitis	Yes / No	Heart defects
Yes / No	Tumors or cancer	Yes / No	Pacemaker Date implanted: ___________________		
Yes / No	Heart murmur	Yes / No	Chemotherapy	Yes / No	Canker or cold sores
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Arthritis/rheumatism
Yes / No	Anemia	Yes / No	Emphysema or other lung disease		
Yes / No	Liver disease	Yes / No	High blood pressure		
Yes / No	Kidney or bladder disease	Yes / No	Seizures	Yes / No	Stroke
Yes / No	Transplants	Yes / No	Tuberculosis	Other: _______________________________	

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Aspirin Yes / No Valium or sedatives Yes / No Codeine or other opioids

Yes / No Penicillin or other antibiotics Yes / No Latex Yes / No Nitrous oxide

Yes / No Local anesthetic

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle Yes or No for each)

Yes / No Tobacco Yes / No Antibiotics Yes/No Aspirin

Yes / No Bisphosphonates (Fosamax, etc.) Yes / No Antidepressants

Yes / No Herbal supplements Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason: ______________________________

Please list all prescription medications:____
____
____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, how many months?_______________________

Yes / No Are you nursing? Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, please explain:
____

Yes / No Have you tested positive for COVID-19? If YES, date of positive test result:
____

Yes / No Are you currently under the care of a physician or taking any medications for any of the conditions listed above? If YES, please list
____
____

Yes / No Are there any issues or conditions that you would like to discuss with the dentist in private?

Occasionally, clearance from the primary care physician is necessary prior to dental treatment. I authorize your office to contact my physician with questions or concerns:

Patient's Signature:____ Date: ___________________________

Physician's Name:____ Phone Number:___________________