Patient Registration Form

American Dental Association
www.ada.org

Email: Today's Date:

Preferred Name: ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Referred by:

Name: Last First Middle Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

Address: Mailing address City: State: Zip:

SS#: Date of Birth: Sex: M F

Employer: Business Phone: *include area code* ( )

Emergency Contact: Relationship: Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

College Student Status: ❑ Full Time ❑ Part Time Please provide school info: School Name:

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired Address:

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed Address 2:

Pref. Pharmacy: Phone: ( ) City, State, Zip:

Dental Insurance Information

Primary Insurance Information

Name of Insured: Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec.: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

ID#: Gr#:

Secondary Insurance Information

Name of Insured: Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec.: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

ID#: Gr#:

Dental Information For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Have you ever had orthodontic (braces) treatments?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Is your home water supply fluoridated?	❑	❑	❑
Do you drink bottled or filtered water?	❑	❑	❑
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❑	❑	❑

	Yes	No	DK
Do you have earaches or neck pains?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you participate in active recreational activities?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

over

Time 9:16 AM | FIRST STATE DENTAL, P.A. | Date 9/21/2015

Dental Medical History

Patient Name: | Birth Date: | Date Created:

Are you currently under a physicians care? ○ Yes ○ No If yes

Physician Name: ○ Yes ○ No If yes

Have you recently been hospitalized or had a major operation? ○ Yes ○ No If yes

Are you taking any medications, pills, or drugs?

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? ○ Yes ○ No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Radiation Treatments ○ Yes ○ No	Alzheimer's Disease ○ Yes ○ No
Diabetes ○ Yes ○ No	Hepatitis ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No	Anaphylaxis ○ Yes ○ No
Drug Addiction ○ Yes ○ No	Renal Dialysis ○ Yes ○ No	Anemia ○ Yes ○ No	Herpes ○ Yes ○ No
Rheumatic Fever ○ Yes ○ No	Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No
Arthritis/Rheumatism ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No	Blood Transfusion ○ Yes ○ No
Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No	Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No
Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No	Bruise Easily ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No
Swelling of Limbs/Gout ○ Yes ○ No	Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Chest Pains ○ Yes ○ No
Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No	Cold Sores/Fever Blisters ○ Yes ○ No
Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No	Congenital Heart Disorder ○ Yes ○ No
Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No	Convulsions ○ Yes ○ No
Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No	Tobacco User ○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____