PATIENT REGISTRATION FORM

Patient No.			Todays Date:		
Name (Last)	(First)	(Middle)	Home Phone No.		Cell Phone No.
Home Address (NO PO BOX #'s and MUST include Apt #)			Business / School Name and Phone No.		
City	State	Zip Code	Drivers License / State ID No.		
Date of Birth	Sex / Height / Weight		Email Address:		
Marital Status:	Social Security No.		In Case of Emergency: Name and Telephone No.		
Responsible Party: Name and Phone No. (Parent or Guardian of patient)			How did you hear about us?		Best way to contact you:

PRIMARY DENTAL INSURANCE INFORMATION

Subscribers' Name (Last)	(First)	(Middle)
Insurance Company Name		
Company Address and Phone No.		
Employer Name	Insured's Soc. Sec. No.	
Insured's DOB	ID No.	Group No.

SECONDARY DENTAL INSURANCE INFORMATION

Subscribers' Name (Last)	(First)	(Middle)
Insurance Company Name		
Company Address and Phone No.		
Employer Name	Insured's Soc. Sec. No.	
Insured's DOB	ID No.	Group No.

YOUR HEALTH HISTORY

Physician's Name and Address		Pharmacy Name and Address	
Physician's Phone No.	Are you Pregnant?	Pharmacy Phone No.	

Have you experienced any reaction or ALLERGY to the following?

	Yes	No		Yes	No		Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐	Aspirin	☐	☐	Allergy- Latex	☐	☐
Barbiturates/Sedatives/Sleeping Pills	☐	☐	Codeine	☐	☐	Metal	☐	☐
Antibiotics (Penicillin, Amoxicillin etc.)	☐	☐	Acrylic	☐	☐	Other Allergies:_____		

Are you taking any of the following:

	Yes	No		Yes	No		Yes	No
Antibiotics	☐	☐	Allergy / Cold Remedies	☐	☐	Digitalis/ Heart Meds	☐	☐
Blood Thinners	☐	☐	Birth Control Pills	☐	☐	Nitroglycerin	☐	☐
Blood Pressure Medication	☐	☐	Tranquillizers	☐	☐	Baby Aspirin 81mg	☐	☐
Thyroid Medication	☐	☐	Insulin / Diabetic Drugs	☐	☐	Aspirin 325mg	☐	☐
Cortisone / Steroids	☐	☐	Recreational Drugs	☐	☐	Osteoporosis Medication	☐	☐

List any and ALL medications you are currently taking: .....

Indicate which of the following you have had or have at the present:

	Yes	No		Yes	No		Yes	No
Epilepsy or Seizures	☐	☐	Arthritis	☐	☐	Radiation Therapy	☐	☐
Heart Attack	☐	☐	Artificial Hip /yr_____	☐	☐	Chemo Therapy	☐	☐
Angina Pectoris	☐	☐	Artificial Knee /yr_____	☐	☐	Hepatitis A (Infectious)	☐	☐
Congenital Heart Disease	☐	☐	Osteoporosis	☐	☐	Hepatitis B (Serum)	☐	☐
Heart Murmur	☐	☐	Diabetes	☐	☐	Hepatitis C (Infectious)	☐	☐
High Blood Pressure	☐	☐	Thyroid DIsorder	☐	☐	Venereal Disease	☐	☐
Arteriosclerosis	☐	☐	Glaucoma	☐	☐	AIDS /HIV	☐	☐
Mitral Valve Prolapse	☐	☐	Cosmetic Surgery	☐	☐	Tuberculosis	☐	☐
Pacemaker	☐	☐	Emphysema	☐	☐	Blood Transfusion	☐	☐
Stroke	☐	☐	Asthma	☐	☐	Hemophilia	☐	☐
Migraines	☐	☐	Lupus	☐	☐	Anemia	☐	☐
Stomach Ulcers	☐	☐	Rheumatic Fever	☐	☐	Sickle Cell Disease	☐	☐
Eating Disorder	☐	☐	Hay Fever	☐	☐	Fainting or Bruise Easily	☐	☐
Depression	☐	☐	HSV / Cold sores	☐	☐	Liver Disease	☐	☐
Drug Addiction	☐	☐	Sinus Problems	☐	☐	Lung Disease	☐	☐
Psychiatric Treatment	☐	☐	Cancer	☐	☐	Kidney Disease	☐	☐

Is there any disease, condition or problem not listed above that you think we should know about,
or is there any activity your doctor says you cannot do? If so explain:.....

Questionare continues -> > >

YOUR DENTAL HISTORY

Date of last dental visit and reason:

Have you ever had any serious trouble associated with previous dental treatment?

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

MOUTH	Yes	No
Bleeding or Sore Gums	☐	☐
Unpleasant Taste/ bad breath	☐	☐
Burning Tongue / Lips	☐	☐
Frequent blisters, Lips / Mouth	☐	☐
Swelling / Lumps in Mouth	☐	☐
Ortho Treatment	☐	☐
Biting Cheek	☐	☐
Clicking / Popping	☐	☐
Difficulty Opening / Closing	☐	☐

TEETH	Yes	No
Loose Teeth	☐	☐
Sensitive to Hot/Cold	☐	☐
Sensitive to Sweets	☐	☐
Sensitive to Biting	☐	☐
Food Impaction	☐	☐
Clenching / Grinding	☐	☐
Shifting of Teeth	☐	☐
Change in Bite	☐	☐

ORAL HYGIENE	Yes	No
Do you use the following?		
Brush	☐	☐
Dental Floss	☐	☐
Fluoride Rinse	☐	☐
Other	☐	☐

How often do you brush?.....
Brush is Soft, Medium, Hard?.....
How often do you floss?.....

Are you happy with the look of your teeth?.....Yes ☐ No ☐ Why?.....

CONSENT:

Your signature attests that the above information is correct to the best of my knowledge and authorizes N F D to take x-rays, study models, photographs and or any other diagnosis of the patient's needs. It is important to know that the use of anesthetic agents may embody a certain risk. I understand that the responsibility for payment for Dental Services provided in this office for myself or dependent is mine, due and payable at time when services are rendered. In the event of default, you are responsible for the interest and indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient / Parent Signature_____Date_____

..... Reviewed by:_____Date_____ .....

What brings you to the office today?