We Welcome You!

The benefits of a healthy smile are immeasurable. Our goal is to help you achieve and maintain optimal oral health. Please fill out the forms completely so that we can provide the best possible care.

Our office is committed to meeting or exceeding the standards of sterilization and infection control mandated by OSHA, the CDC and the ADA. We will be happy to answer any questions you may have regarding our infection control procedures.

PATIENT REGISTRATION

Date _____ (PLEASE PRINT) Home Phone _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex: ☐ M ☐ F Age _____ Birthdate _____ Cell Phone _____

☐ Single ☐ Married ☐ Other _____ **Preferred e-mail** _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse / Significant Other's Name _____

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone _____

Referred by: ☐ Friend ☐ Relative ☐ Doctor: _____
☐ Location ☐ Print Ad ☐ Internet

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check boxes that apply):

- ☐ Artificial Joint
- ☐ Artificial Heart Valve
- ☐ Mitral Valve Prolapse
- ☐ Blood Disease
- ☐ Blood Thinning Medications
- ☐ Circulatory Problems
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Stroke
- ☐ Arthritis
- ☐ Cancer (type) _____
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Osteoporosis/Bisphosphonates
- ☐ Psychiatric Care
- ☐ Epilepsy/Seizures
- ☐ Alzheimer's/Dementia
- ☐ Chemical Dependency
- ☐ Eating Disorder
- ☐ Digestive Disorders (Ulcer, Colitis, IBS, GERD, Crohn's, Celiac)
- ☐ Diabetes (type) _____
- ☐ AIDS HIV Positive
- ☐ Immunosuppressive Disease
- ☐ Sexually Transmitted Disease
- ☐ Asthma
- ☐ Respiratory Disease
- ☐ Headaches Migraines
- ☐ Hepatitis Liver Disease
- ☐ Kidney Disease
- ☐ Thyroid Disease

Drug allergies/adverse reactions: ☐ **Aspirin** ☐ **Codeine** ☐ **Latex** ☐ **Local Anesthetic (Novocaine)** ☐ **Penicillin** ☐ **Sulfa** ☐ **Other** _____

_____

What medications are you currently taking? (prescription, non-prescription, dietary/herbal supplements) _____

_____

Are you currently under the care of a physician? ☐ **Yes** ☐ **No** **If yes, explain** _____

_____

(Women) Check boxes that apply: ☐ **Pregnant** ☐ **Nursing** ☐ **Taking oral contraceptives** _____

Please list any other medical conditions/prior surgeries not included above: _____

_____

_____

Tobacco Use: ☐ **Never** ☐ **Past** ☐ **Present** **Type:** _____ **How Long:** _____

(OVER)

DENTAL HISTORY

Reason for today's visit ______________________________

If you have ever had any complications or unfavorable experiences during dental treatment, please explain: ______________________________

____

____

Do you have, or have you ever had, any of the following? (check boxes that apply):

- ☐ Grinding/Clenching Teeth
- ☐ Jaw Pain or Tiredness
- ☐ Clicking/Popping of Jaw
- ☐ Pain Around Ear
- ☐ Broken Fillings
- ☐ Loose Teeth
- ☐ Bleeding Gums
- ☐ Swollen or Tender Gums
- ☐ Periodontal (Gum) Treatment, Year __________
- ☐ Bad Breath
- ☐ Unpleasant Taste
- ☐ Blisters on Lips
- ☐ Sores in Mouth
- ☐ Swelling or Lumps in Mouth
- ☐ Burning Sensation of Tongue
- ☐ Cigarette, Pipe, Cigar Smoking
- ☐ Smokeless Tobacco Habit
- ☐ Dry Mouth
- ☐ Food Trapping Between Teeth
- ☐ Sensitivity to Chewing
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Mouth Breathing
- ☐ Cheek Biting
- ☐ Fingernail Biting
- ☐ Foreign Object Chewing
- ☐ Ice Chewing
- ☐ Orthodontic Treatment, Age ______

Date of last dental cleaning ______________________ Date of last dental X-rays ______________________

Date wisdom teeth extracted, if applicable ______________________

Do you have any questions regarding your teeth or gums? ______________________________

____

If you could change or improve anything with your teeth or smile, what would it be? ______________________________

____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize dental care performed by the dentist and staff. I assume financial responsibility for this treatment.

______________ ______________________________
Date *Signature*

Payment in full is due at the time of treatment unless prior arrangements have been approved. We will be happy to assist our patients with insurance claims so that reimbursement can be made directly to the patient from the insurance carrier.

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

MEDICAL HISTORY UPDATE – TO BE COMPLETED AT FUTURE APPOINTMENTS

After reviewing medical history, have there been any changes in your health since your last dental appointment? ☐ **Yes** ☐ **No**

Please list changes: ______________________________

Are you taking any new medications? __________ **If so, what** ______________________________

______________ ______________________________
Date ***Signature***

MEDICAL HISTORY UPDATE – TO BE COMPLETED AT FUTURE APPOINTMENTS

After reviewing medical history, have there been any changes in your health since your last dental appointment? ☐ **Yes** ☐ **No**

Please list changes: ______________________________

Are you taking any new medications? __________ **If so, what** ______________________________

______________ ______________________________
Date ***Signature***

MEDICAL HISTORY UPDATE – TO BE COMPLETED AT FUTURE APPOINTMENTS

After reviewing medical history, have there been any changes in your health since your last dental appointment? ☐ **Yes** ☐ **No**

Please list changes: ______________________________

Are you taking any new medications? __________ **If so, what** ______________________________

______________ ______________________________
Date ***Signature***