PATIENT REGISTRATION

PATIENT NAME		DATE OF BIRTH
PARENTS NAME (if child)		SS #
ADDRESS		DRIVERS LICENSE#
CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	CELL PHONE
PATIENTS EMPLOYER		OCCUPATION
SPOUSES NAME	EMPLOYER	WORK PHONE
PRIMARY INSURANCE		SECONDARY INSURANCE
SUBSCRIBERS NAME		SUBSCRIBERS NAME
SOCIAL SECURITY #		SOCIAL SECURITY #
DATE OF BIRTH		DATE OF BIRTH
GROUP NUMBER		GROUP NUMBER
PREVIOUS DENTIST		PHONE NUMBER
LAST VISIT		
EMERGENCY CONTACT		PHONE NUMBER
WHO MAY WE THANK FOR REFERRING YOU?		

DENTAL HISTORY

—Please check any you would answer "YES"—

- ☐ Is there anything you dislike about your smile?
- ☐ Do you want complete dental care?
- ☐ Are you apprehensive about dental treatment?
- ☐ Have you had problems with previous dental treatment?
- ☐ Do you gag easily?
- ☐ Have you had problems with local anesthetic, getting numb for dental treatment?
- ☐ Have you had braces?
- ☐ Have you been told you have gum disease?
- ☐ Have you had periodontal treatment or gum surgery?
- ☐ Do you have dentures or removable partial dentures?
- ☐ Do you have difficulty chewing food?
- ☐ Do you catch food between your teeth?
- ☐ Do you chew only on one side of your mouth?
- ☐ Do you avoid brushing any area because of pain?
- ☐ Do your gums bleed easily?
- ☐ Do you get a bad taste in your mouth?
- ☐ Do you have bad breath?
- ☐ Do you have lumps or swelling in your mouth?
- ☐ Do you get frequent blisters in or around your mouth?
- ☐ Are your teeth sensitive to cold, heat, pressure, or sweets?
- ☐ Do you have oral habits, such as nail biting, ice chewing, thumb sucking or mouth breathing?
- ☐ Does your tongue burn?

  How often do you brush your teeth? _____

  How often do you floss your teeth? _____
- ☐ Does your jaw make noises that bother you or others?
- ☐ Do you clench or grind your teeth?
- ☐ Does your jaw ever feel tired?
- ☐ Does your jaw ever get stuck so that you can't open freely?
- ☐ Does it hurt when you chew or open wide to take a bite?
- ☐ Do you have earaches or pain in front of your ears?
- ☐ Do you have any jaw symptoms or headaches upon awaking in the morning?
- ☐ Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?
- ☐ Do you take medication for jaw pain or discomfort?
- ☐ Do you have pain in the face, cheeks, jaws, joints, throat or temples?
- ☐ Have you been told you have TMD or TMJ problems?
- ☐ Are you unable to open your mouth as wide as you want?
- ☐ Are you aware of an uncomfortable bite?
- ☐ Have you had a blow to the jaw or mouth?
- ☐ Are you a gum chewer or pipe smoker?
- ☐ Have you ever been premedicated with antibiotics or sedatives for dental treatment?

MEDICAL HEALTH HISTORY

Do you have, or have you had, an of the following?
—CHECK ALL THAT APPLY—

Heart problems
- ____ Chest pain or angina
- ____ Shortness of breath
- ____ Blood pressure problem
- ____ Heart surgery or stent placement
- ____ Heart murmur
- ____ Heart valve problem
- ____ Heart attack, date _____
- ____ Rheumatic fever
- ____ Pacemaker
- ____ Artificial Heart valve
- ____ Congestive heart disease or COPD
- ____ Irregular heart beat (arrhythmia)
- ____ TAKING HEART PILLS _____

Blood problems
- ____ Easy bruising
- ____ Frequent nose bleeds
- ____ Abnormal bleeding or clotting
- ____ Anemia or blood disease
- ____ Ever needed blood transfusion

Vascular disease
- ____ Aneurysm
- ____ Stroke/ TIA

Allergies
- ____ Hay fever
- ____ Sinus problems
- ____ Skin rashes
- ____ Taking allergy pills
- ____ Asthma

Intestinal problems
- ____ Ulcers or Colitis
- ____ Weight gain or loss
- ____ Special diet
- ____ Constipation or diarrhea
- ____ Kidney or Bladder problems
- ____ Heartburn or Reflux (GERD)
- ____ Bulimia or Anorexia

Bone or Joint problems
- ____ Arthritis
- ____ Osteoporosis
- ____ Joint replacement
- ____ Back or neck pain
- ____ Taken Fosamax

Diabetes
- ____ YOU/Family history
- ____ Urinate more than 6 times a day
- ____ Frequent thirst or dry mouth

Autoimmune
- ____ Fibromyalgia
- ____ HIVpositive/ AIDS
- ____ Lupus

Neurological
- ____ Epilepsy/ Seizure disorder
- ____ Migraines/ Frequent headaches
- ____ Alzheimers
- ____ History of head injury

NOTES _____

Other Conditions
- ____ Thyroid disease
- ____ Persistent cough or swollen glands
- ____ Organ transplant
- ____ Cancer or tumors
- ____ Chemotherapy or radiation
- ____ Liver disease/ Jaundice/ Hepatitis
- ____ Glaucoma
- ____ Claustrophobia
- ____ Do you wear contacts
- ____ Herpes, HPV or other STD's
- ____ Tuberculosis or other respiratory disease
- ____ History of drug or alcohol abuse
- ____ Do you drink alcohol? How much? _____
- ____ Do you smoke or chew? How much? _____

Are you allergic, or have reacted adversely, to any?
- ____ Local anesthetics ("Novocaine")
- ____ Penicillin, other antibiotics, sulfa drugs
- ____ Aspirin, Tylenol, Ibuprofen
- ____ Codeine or other narcotics
- ____ Sedatives or barbiturates
- ____ Reaction to metals
- ____ Latex
- ____ Other

WOMEN
- ____ Are you taking birth control pills?
- ____ Are you pregnant? Due date _____
- ____ Are you nursing?
- ____ Have you reached menopause?
- ____ **Do you know birth control pills can be inactivated by antibiotic usage?**

During the past 12 months, have you taken any of these?
- ____ Antibiotics or sulfa drugs? _____
- ____ Anticoagulants, Coumadin etc. _____
- ____ High blood pressure drugs _____
- ____ Tranquilizers _____
- ____ Insulin, Orinase etc. _____
- ____ Aspirin _____
- ____ Digitalis or heart drugs _____
- ____ Nitroglycerine _____
- ____ Cortisone (steroids) _____
- ____ Natural Remedies _____
- ____ Nonprescription drugs _____
- ____ **OTHER** _____

Patient/Parent Signature:

_____

_____

Date: _____

Reviewed by: