## **Patient Registration Form**

Date of Appointment:

Patient	lusfa uma	
Palleni	ımımı	allor

Patient's First Name			Middle Name		Last Name	(as	s it appears on insurance card or ID)	
Sex	Marital Status		Date of Birth (Age)	Social Security		Number		
Patient's Address	1			City	1	State	Zip	
Home Phone			Mobile Phone		Email Address			
Referred by								
Patient Employer/School	Information							
Employer/School			Occupation		Employer/Scho	ol Phone		
Employer/School Address			City			State Zip		
Emergency Contact Inform	nation							
Emergency Contact Name			Emergency Contact Phone		Relation to Pati	Relation to Patient		
Billing and Insurance	ee				1			
Primary Dental Insurance								
Insurance Company				Plan				
Plan Number		Group Number		Insured's Employer/School	d's Employer/School			
Insured's Name (as it appears o	n insurance card c	or ID)		Relation to Patient	Insured's Phone Number		e Number	
Insured's Address				City			Zip	
Insured's Social Security Numb	er	Insured's Birthdate						
Secondary Dental Insuran	ce							
Insurance Company				Plan				
Plan Number		Group Number		Insured's Employer/School	Insured's Social Security Number		al Security Number	
Insured's Name (as it appears o	sured's Name (as it appears on insurance card or ID)			Relation to Patient In		Insured's Phone Number		
Responsible Party						I		
Billing Name (if other than patient)			Phone	Relation to Pati	Relation to Patient			
Address			City		State	Zip		
0			-		-			
Signature of Patient or Authoriz	ed Guardian			Date				

Do you have any other allergies?	News				Date of Appointment:			
What brings you to the office today?  Are you allergic to any of the following? Adherow Tape   Artibiotics   Latex   Artibiotics   Latex   Artibiotics   Latex   Artibiotics   Latex			Gender	Age				
Adhesive Tope	Reason for Visit				Allergies			
Bestitutates Steeror Pitel   Asprim   codine   Sulfa   Local Anesthet   Do you have any other allergies?	What brings you to the office today?			Are you allergic to any	of the following?			
Current Medications					Adhesive Tape	Antibiotics	Latex	
Current Medications  Are you currently taking any blood thinners?   Yes   No					Barbiturates (Sleeping P	Pills) Aspirin	lodine	
Name   Reaction   Name   N					Codeine	Sulfa	Local Anesthetics	
Name   Beaction   Hospitalizations & Surgeries					Do you have any other	allergies?		
Mane	Current Medication	ons			Name	Reaction		
Name		ng any blood thinners?						
Name Dosage Frequency Name Name Dosage Frequency Name Name Name Name Name Name Name Name	What medications are	you currently taking?			Hospitalizations &	k Surgeries		
Reason   Date					Reason		Date	
Date   Date   Date	Name				Reason		Date	
Dental History  When was your last dental exam? Date	Name		Dosage	Frequency				
Have you ever had periodontal (gum) treatments?	Name		Dosage	Frequency	Reason		Date	
Date	Dental History							
When were your last dental x-rays taken?  Date	When was your last d	lental exam?			Have you ever had pe	eriodontal (gum) treatmen	its?	
Bad Breath   Dry Mouth   Partials	Date				Yes No			
How often do you brush? How often do you floss?  # times/day # times/day # times/day   Blisters on Mouth   Ear Pain   Sensitivity to Part   Sensitivity to	When were your last of	dental x-rays taken?			Do you have any of the	e following?		
How often do you brush? How often do you floss?  # times/day  # times/day  # times/day    # times/week    # ti	Date				Rad Breath	Dry Mouth	Partials	
# times/day # times/day   # times/day   Blisters on Mouth   Ear Pain   Sensitivity to H   Croken Fillings   Jaw Pain   Sensitivity to S   Cicking Jaw   Loose Teeth   Sensitivity to S   Cicking Jaw   Loose Teeth   Sensitivity to S   Cicking Jaw   Loose Teeth   Sensitivity to S   Dentures   Mouth Pain   Swollen Guns   Swollen Guns   Mouth Pain   Swollen Guns   Mouth	How often do you bru	ish? How off	en do vou flo	997		= '		
Broken Fillings	· ·		-				Sensitivity to Heat	
Yes			iay		Broken Fillings	Jaw Pain	Sensitivity to Sweets	
Have you ever had orthodontic (braces) treatment?    Yes   No		etn?			Clicking Jaw	Loose Teeth	Sensitivity to Pressure	
Past Medical History  Have you ever had any of the following?   Alcoholism	Yes No				Dentures	Mouth Pain	Swollen Gums	
Past Medical History  Have you ever had any of the following?  Alcoholism   Bleeding Disorder   Eating Disorder   High Cholesterol   Migraines   Stomach Ulcer   Osteoporosis   Substance Abuse   Stomach Ulcer   Osteoporosis   Substance Abuse   Anemia   Blood Transfusion   Hay Fever   Kidney Disorder   Pacemaker   Thyroid Disorder   Anxiety Disorder   Bowel Disorder   Heart Disease   Liver Disorder   Rheumatic Fever   Tuberculosis   Arthritis   Cancer   Heart Problems   Lung Disease   Sinus Problems   Venereal Disease   Asthma   Diabetes   Hepatitis - A, B, or C   Lupus   Skin Disorder   Measles   Stroke    Lifestyle Factors  Lifestyle Factors  Women Only  Are you pregnant?   Are you breastfeeding?   Yes   No   Yes   No   Yes   No   Yes   No   What is your method of birth control?	Have you ever had or	thodontic (braces) treat	ment?		Difficulty Opening or C	Closing Mouth Sores		
Have you ever had any of the following?  Alcoholism Bleeding Disorder Eating Disorder Joint Disorder Osteoporosis Substance Abuse Anemia Blood Disease Epilepsy Joint Disorder Pacemaker Thyroid Disorder Anxiety Disorder Bowel Disorder Heart Disease Liver Disorder Rheumatic Fever Tuberculosis Arthritis Cancer Heart Problems Lung Disease Sinus Problems Venereal Disease Asthma Diabetes Hepatitis - A, B, or C Lupus Skin Disorder AIDS / HIV Depression High Blood Pressure  Women Only  Have you ever smoked?  Yes No # of years # packs/day  Do you use recreational drugs?  Yes No types? # times/week  # drinks/week  How much alcohol do you drink per day?	Yes No							
Alcoholism Bleeding Disorder Eating Disorder Disorder Blood Disease Epilepsy Joint Disorder Osteoporosis Substance Abuse Anemia Blood Transfusion Hay Fever Kidney Disorder Pacemaker Thyroid Disorder Anxiety Disorder Bowel Disorder Heart Disease Liver Disorder Rheumatic Fever Tuberculosis Arthritis Cancer Heart Problems Lung Disease Sinus Problems Venereal Disease Asthma Diabetes Hepatitis - A, B, or C Lupus Skin Disorder Measles Stroke  Lifestyle Factors  Lifestyle Factors  Have you ever smoked?  Yes No # of years # packs/day   What is your method of birth control?  Women Only  Are you breastfeeding?  Yes No # packs/day   What is your method of birth control?  What is your method of birth control?  What is your method of birth control?	Past Medical Hist	ory						
Allergies Blood Disease   Epilepsy   Joint Disorder   Osteoporosis   Substance Abuse   Anemia   Blood Transfusion   Hay Fever   Kidney Disorder   Pacemaker   Thyroid Disorder   Anxiety Disorder   Bowel Disorder   Heart Disease   Liver Disorder   Rheumatic Fever   Tuberculosis   Arthritis   Cancer   Heart Problems   Lung Disease   Sinus Problems   Venereal Disease   Asthma   Diabetes   Hepatitis - A, B, or C   Lupus   Skin Disorder   Measles   Stroke    Lifestyle Factors   Women Only    Are you ever smoked?   Women Only   Are you breastfeeding?   Yes   No  # packs/day   Yes   No  # packs/day    Do you use recreational drugs?   # times/week   # drinks/week   # drinks/week   How much alcohol do you drink per day?    How much acfeline do you drink per day?								
Anemia Blood Transfusion Hay Fever Anxiety Disorder Bowel Disorder Heart Disease Arthritis Cancer Heart Problems Asthma Diabetes Hepatitis - A, B, or C AlDS / HIV Depression High Blood Pressure  Lifestyle Factors  Have you ever smoked? Yes No # of years # packs/day  Do you user recreational drugs? Yes No types? # times/week  How much alcohol do you drink per week? # drinks/week  How much caffeine do you drink per day?    Anxiety Disorder   Pacemaker   Thyroid Disorder     Liver Disorder   Rheumatic Fever   Tuberculosis     Lung Disease   Sinus Problems   Venereal Disease     Lupus   Skin Disorder     Measles   Stroke     Women Only  Are you pregnant?   Are you breastfeeding?     Yes No Yes No Yes No Yes No     What is your method of birth control?     What is your method of birth control?	Alcoholism	Bleeding Disorder	Eating	Disorder	High Cholesterol	Migraines	Stomach Ulcer	
Anxiety Disorder Bowel Disorder Heart Disease Arthritis Cancer Heart Problems Asthma Diabetes Hepatitis - A, B, or C AIDS / HIV Depression High Blood Pressure  Lifestyle Factors  Have you ever smoked? Yes No # of years # packs/day  Do you user recreational drugs? Yes No types? # times/week  How much alcohol do you drink per week? # drinks/week  How much caffeine do you drink per day?  Liver Disorder   Rheumatic Fever   Tuberculosis   Lung Disease   Sinus Problems   Venereal Disease   Lung Disease   Skin Disorder   Measles   Stroke    Women Only  Are you pregnant?   Are you breastfeeding?   Yes No Yes No Yes No   Yes No   What is your method of birth control?	Allergies	Blood Disease	Epilep	sy	Joint Disorder	Osteoporosis	Substance Abuse	
Arthritis Cancer Heart Problems Lung Disease Sinus Problems Venereal Disease Asthma Diabetes Hepatitis - A, B, or C Lupus Skin Disorder Measles Stroke  Lifestyle Factors  Have you ever smoked? Yes No # of years # packs/day  Do you usmoke now? Yes No # packs/day  Do you use recreational drugs? Yes No types? # times/week  How much alcohol do you drink per week? # drinks/week  How much caffeine do you drink per day?	Anemia	Blood Transfusion	Hay Fe	ever	Kidney Disorder	Pacemaker	Thyroid Disorder	
Ashma Diabetes Hepatitis - A, B, or C Lupus Skin Disorder  AIDS / HIV Depression High Blood Pressure  Women Only  Are you pregnant? Are you breastfeeding?  Yes No # of years # packs/day  Do you smoke now?  Yes No # packs/day  Do you use recreational drugs?  Yes No types? # times/week  How much alcohol do you drink per week?  # drinks/week  How much caffeine do you drink per day?	Anxiety Disorder	Bowel Disorder	Heart	Disease	Liver Disorder	Rheumatic Fever	Tuberculosis	
Lifestyle Factors  Have you ever smoked?  Yes No # of years # packs/day  Do you smoke now?  Yes No # packs/day  Do you use recreational drugs?  Yes No types? # times/week  How much alcohol do you drink per week?  # drinks/week  How much caffeine do you drink per day?  Measles  Stroke  Women Only  Are you breastfeeding?  Yes No Yes No Yes No  What is your method of birth control?  What is your method of birth control?	Arthritis	Cancer	Heart	Problems	Lung Disease	Sinus Problems	Venereal Disease	
Lifestyle Factors  Have you ever smoked?  Yes No # of years # packs/day  Do you smoke now?  Yes No # packs/day  Do you use recreational drugs?  Yes No types? # times/week  How much alcohol do you drink per week?  # drinks/week  How much caffeine do you drink per day?	Asthma	Diabetes	Hepati	itis - A, B, or C	Lupus	Skin Disorder		
Have you ever smoked?  Yes No # of years # packs/day  Do you smoke now?  Yes No # packs/day  Do you use recreational drugs?  Yes No types? # times/week  # drinks/week  How much caffeine do you drink per day?  Are you pregnant?  Yes No Yes No Yes No  Yes No  What is your method of birth control?  What is your method of birth control?	AIDS / HIV	Depression	High E	Blood Pressure	Measles	Stroke		
Yes No # of years # packs/day Yes No Yes No  Do you smoke now?  Yes No # packs/day  Do you use recreational drugs?  Yes No types? # times/week  # drinks/week  How much alcohol do you drink per week?  # drinks/week  How much caffeine do you drink per day?	Lifestyle Factors				Women Only			
Do you smoke now?  Yes No # packs/day  Do you use recreational drugs?  Yes No types? # times/week  How much alcohol do you drink per week?  # drinks/week  How much caffeine do you drink per day?	Have you ever smoked	1?			Are you pregnant?	Are you b	reastfeeding?	
Yes No # packs/day  Do you use recreational drugs?  Yes No types? # times/week  How much alcohol do you drink per week?  # drinks/week  How much caffeine do you drink per day?	Yes No # of years # packs/day		Yes No	Yes	s No			
Do you use recreational drugs?  Yes No types? # times/week  How much alcohol do you drink per week?  # drinks/week  How much caffeine do you drink per day?	Do you smoke now?				What is your method o	of birth control?		
Yes No types? # times/week  How much alcohol do you drink per week?  # drinks/week  How much caffeine do you drink per day?	Yes No # pa	acks/day						
How much alcohol do you drink per week?  # drinks/week  How much caffeine do you drink per day?	Do you use recreationa	al drugs?						
# drinks/week ———————————————————————————————————	Yes No type	es?	# times/we	eek				
How much caffeine do you drink per day?	How much alcohol do	you drink per week?						
	# drinks/week							
# drinks/day	How much caffeine do	you drink per day?						
	# drinks/day							