**PATIENT REGISTRATION**

Today's Date _____

Patient Legal Name (First, M.I., Last) _____

Age _____ Date of Birth _____

Sex: M / F Marital Status: M / S / W / D

Home Address _____

City/State/Zip _____

Home Phone _____ Cell Phone _____

Email _____

Social Security No. _____ Patient's Employer _____

Occupation _____ Bus Phone _____

Person Responsible for Account (Legal Name) _____

Relationship to Patient _____ Occupation _____

Address (if different from above) _____

City, State, Zip _____

Bus. Phone _____ Home Phone _____

In Case of Emergency Contact: (spouse or nearest relative) _____

Relationship to Patient _____

Home Phone _____ Work Phone _____

Primary Dental Insurance Program _____

Subscriber's Legal Name _____

Address (if different from above) _____

City, State, Zip _____

Date of Birth _____ Employer _____

Work Phone _____ Social Security No. _____

Secondary Dental Insurance _____

Subscriber's Legal Name _____

Address (if different from above) _____

City, State, Zip _____

Date of Birth _____ Employer _____

Work Phone _____ Social Security No. _____

PLEASE ANSWER THE FOLLOWING QUESTIONS.
THIS WILL BETTER HELP US TO BETTER SERVE YOU.

1. How long has it been since your last:
   Dental Checkup & Examination?_____ Cleaning?_____ Full mouth x-rays? _____
2. Are you having any pain? Yes or No_____ If so, how long? _____
3. Do your gums bleed easily? Yes or No_____
   If so, have you had previous special treatment for your gums?_____
   When? _____
4. What are the best times for your dental appointments? Anytime or other (list times & days)
   _____
5. If we have changes in our schedule, would you like us to contact you on a short call basis so you can be seen sooner? Yes or No
6. How did you find out about our Dental Office? Family, Friend, Flyer, Yellow Pages, or Other (please identify) _____
7. What is the reason for your visit to our office today? _____
   _____

(over)

## MEDICAL HISTORY

1. Are you in good health? _____
2. Are you under a physician's care now? _____
   If so, please give reason for treatment _____
   _____
3. Has your physician ever recommended pre-medication for dental treatment? _____
4. Are you taking any kind of medication at this time? _____
   If so, what? _____
5. Do you have, or have you had any of the following? (please circle)

| | | |
|---|---|---|
| Allergies | Tuberculosis | Anemia |
| Kidney or Liver Trouble | Rheumatic Fever | Diabetes |
| Heart Trouble | Asthma | Infectious Hepatitis |
| Epilepsy | Glaucoma | HIV Positive |
| Artificial Prosthesis | Chest Pains | Pain in Jaw Joints |
| Frequent Headaches | Bruise Easily | Artificial Heart Valve |
| Artificial Joint | Mitral Valve Prolapse | Hepatitis A |
| Hepatitis B or C | High Blood Pressure | Cancer |
| Chemotherapy | Other _____ | |

6. Have you ever had trouble with prolonged bleeding after surgery? _____
7. Have you ever had any unusual reaction to an anesthetic or drug (like penicillin or codeine)?
   If so, what? _____
8. Is there any other information that should be known
   about your health? _____
   about previous dental visits? _____
9. Do you use tobacco? _____
8. Women: Are you pregnant? _____ Are you taking oral contraceptive? _____

Signature _____

*NOTE:*

*In our office, we recognize the person bringing in a minor as the responsible party.*

*Due to increased cost of filing insurance, and the delays of receiving payment, we are now requiring a 20% down payment for services given that day. Major dental restorative work (crowns, bridges, dentures, partials, implants, etc.) will require a 50% down payment.*