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COMPREHENSIVE FAMILY DENTISTRY

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Patient Registration Form

____ / ____ / ____
Date

_____ ____ / ____ / ____ ☐ Male ☐ Female
Name (last, first, m.) Date of Birth

____ - ____ - ____ ☐ Home ☐ Work ☐ Cell (____) _____ (____) _____
Social Security Number Indicate the best number to reach you at with a ✓

Mailing Address | City | State | Zip

Email | Employer | Occupation

Person Responsible for Account | Relation to Patient | (____) Phone

Mailing Address | City | State | Zip

Is there anyone else who you would like to designate to discuss your treatment?

Name (last, first) | (____) Phone | Relation to Patient

How did you hear about your office?

Please tell us about yourself (Interests/Hobbies) ☐ Married Spouses Name ☐ Single ☐ Other

Spouses Employer | Spouses Occupation

DENTAL INSURANCE INFORMATION

Primary Insurance Coverage	Secondary Insurance Coverage
Employer Name	Employer Name
Subscriber's Name & Date of Birth	Subscriber's Name & Date of Birth
Subscriber's SSN or ID	Subscriber's SSN or ID
Group #	Group #

Signature (Patient or Parent/Guardian if Under 18) ____ / ____ / ____ Date

Name (last, first, m.) _____ / _____ / _____ Date of Birth

HEALTH QUESTIONNAIRE

There are many medical situations which can affect or be affected by the procedures or drugs used in dentistry. Therefore, please fill out the following information VERY carefully. Thank you.

Are you presently ill or under the care of a physician? ☐ Yes ☐ No _____ If yes, please describe

_____ / _____ / _____ Date of last MEDICAL exam _____ Physician's Name

Do you have, or have you had: (Please check at the RIGHT of each item)

(Check each item)	Yes	No	Don't Know	(Check each item)	Yes	No	Don't Know	(Check each item)	Yes	No	Don't Know
Allergies (medications, other)				Jaundice				Diabetes (indicate type):			
If yes, please list here:				Epilepsy or Seizures				Kidney problems			
				Hearing aid(s)/Hard of hearing				Venereal disease			
Heart problems				Glaucoma, Eye disorders				Thyroid disease			
High blood pressure				Cold sores (Herpes)				HIV positive/AIDS			
Rheumatic fever				Persistent cough				Arthritis			
Heart murmur				Emphysema				Painful joints (including jaw)			
Heart surgery				Tuberculosis				Prosthetic joint(s)			
Prosthetic heart valve(s)				Asthma				Drug addition			
Pacemaker				Sinus problems				Alcoholism			
Angina (Chest pain)				Anemia				Smoke or chew tobacco			
Stroke				Hemophilia, bleeding disorders				Fainting or dizzy spells			
Hepatitis (indicate type):				Bruise or bleed easily				Cancer/Radiation therapy			
Liver disease				Ulcers				Heart burn/Acid reflux			

Are you taking any medications/drugs for the following? ☐ Heart Condition ☐ Oral Contraceptives ☐ High Blood Pressure ☐ Cortisone or Steroids ☐ Anticoagulants (blood thinners) ☐ Sedatives, Tranquilizers or Antidepressants

List all current medications, conditions or medical treatments not listed above (including over the counter medications and vitamins).

DENTAL QUESTIONNAIRE:

Do you have any of the following? Indicate with a ✓

☐ Concerns w/ appearance of teeth
☐ Teeth sensitive to cold, hot, sweets or pressure
☐ Bleeding gums
☐ Food impaction
☐ Clenching or grinding
☐ Removable dental appliance
☐ Swelling or lumps in mouth
☐ Unpleasant taste
☐ Pain around ear
☐ Unusual sounds in ear while eating
☐ Unpleasant dental experience
☐ Complications from extractions
☐ Periodontal treatment
☐ Orthodontic treatment
☐ Mouth breathing
☐ Bad breath
☐ Snoring or problems sleeping
☐ Other

_____ / _____ / _____ Date of last dental exam _____ Any previous dental treatment?

I acknowledge that I am responsible for the accuracy of the above information. I will notify my dentist if there is a change to any of my health and dental history, medications, allergies, contact information and insurance information. I hereby certify that the above information is true and correct to the best of my knowledge.

_____ Signature (Patient or Parent/Guardian if Under 18) _____ / _____ / _____ Date