PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name ____________________________ Preferred Name _________________________ Date ________________

Address ___________________________ City ____________________ State / Prov. ________ Zip / P.C. ___________

E-Mail _____________________________ Cell Phone _____________________ Home Phone ____________________

SS# / SIN ____ Birthdate ____

Sex: ▢ MALE ▢ FEMALE Gender You Identify As: ____

Check Appropriate Box: ▢ MINOR ▢ SINGLE ▢ MARRIED ▢ DIVORCED ▢ WIDOWED ▢ SEPARATED

If College Student, F.T. / P.T., Name of School ____________________ City ________________ State / Prov. _______

Patient's or Parent's / Guardian's Employer _________________________________ Work Phone __________________

Business Address _________________________ City _________________ State / Prov. ________ Zip / P.C. ________

Spouse or Parent's / Guardian's Name ____

Employer ____ Work Phone ______________________________________

Whom May We Thank for Referring You? ____

Person to Contact in Case of an Emergency _____________________________________ Phone __________________

RESPONSIBLE PARTY

Name of Person Responsible for this Account ____________________________ Relationship to Patient _____________

Phone _________________________ SS# / SIN _____________________ Employer ____________________________

Is this Person Currently a Patient in Our Office? ▢ YES ▢ NO

INSURANCE INFORMATION

We can only file if we have updated information. Please provide the reception desk with name of insured, relationship to patient, and insurance card if available. We'll need SSN of the policy holder and or policy #.

This form gives us permission to contact the policy holder. If you do not have the information on hand, provide information here:

Name of Insured ____ Relationship to Patient ______________

Birthdate _________________________ SS# / SIN _________________________ Date Employed ____________

Name of Employer ____ Work Phone _______________________

Employer Address _____________________ City ________________ State / Prov. ________ Zip / P.C. _______

Insurance Company ___________________________________ Tel. Number ______________________________

GRP # _____________________________________ Policy / I.D. # _____________________________________

Insurance Co. Address __________________ City ________________ State / Prov. ________ Zip / P.C. _______

X ____

Signature of Patient or Parent Guardian If Minor

PATIENT'S DENTAL & MEDICAL HISTORY

Patient Name ________________________________ Birth Date ___________________ Date ____________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

DENTAL HISTORY

Reason for this visit: ____

When was your last dental visit? ____

What was done? ____

Previous Dentist (Name & Location) ____

Have you had a complete series of dental films (x-rays) taken? ☐ YES ☐ NO

If yes, when/where? ____

How often do you brush your teeth? _______________________ How often do you floss? _______________________

Is your drinking water fluoridated? ☐ YES ☐ NO

Do your gums bleed while brushing or flossing? ☐ YES ☐ NO

Are your teeth sensitive to hot or cold liquids/foods? ☐ YES ☐ NO

Are your teeth sensitive to sweet or sour liquids/foods? ☐ YES ☐ NO

Do you feel pain to any of your teeth? ☐ YES ☐ NO

Do you have any sores or lumps in or near your mouth? ☐ YES ☐ NO

Do you have any of these habits? ☐ Thumb sucking ☐ Nail biting ☐ Cheek/lip biting ☐ Chewing on ice/foreign objects

Have you noticed any loosening of your teeth? ☐ YES ☐ NO

Does food tend to become caught between your teeth? ☐ YES ☐ NO

Have you ever had periodontal treatment (gums) ? ☐ YES ☐ NO

Have you ever had any difficult extractions in the past? ☐ YES ☐ NO

Have you ever had any prolonged bleeding following extractions? ☐ YES ☐ NO

Do/did your parents have dentures? ☐ YES ☐ NO

If you could change anything about your smile, what would you change? _______________________________________

____

____

Have you had any head, neck, or jaw injuries? ☐ YES ☐ NO If yes: ______________________________________

Have you ever experienced any of the following problems with your jaw?

☐ Clicking ☐ Pain (Joint, Ear, Side of Face) ☐ Difficulty in opening or closing ☐ Difficulty in chewing

Do you have frequent headaches? ☐ YES ☐ NO

Do you have any of these sleep patterns or conditions:

☐ Sleep apnea ☐ Snoring ☐ Daytime drowsiness ☐ Bed wetting (for children)

Do you clench or grind your teeth? ☐ YES ☐ NO

Have you ever worn a bite plate or other appliance? ☐ YES ☐ NO

MEDICAL HISTORY

Are you in good health? ☐ YES ☐ NO

Date of your last physical exam: ______________________________

Are you now under the care of a physician? If yes, please list Physician's Name ☐ YES ☐ NO

If yes: ______________________________

Have you ever been hospitalized or had a major operation? ☐ YES ☐ NO

If yes: ______________________________

Are you taking any medications, pills, or drugs? ☐ YES ☐ NO If yes, please fill out medication list separately.

Have you had any abnormal bleeding? ☐ YES ☐ NO

If yes: ______________________________

Do you bruise easily? ☐ YES ☐ NO

Have you ever required a blood transfusion? ☐ YES ☐ NO

Have you had a recent weight loss? ☐ YES ☐ NO

Do you take, or have you taken Phen-Fen or Redux? ☐ YES ☐ NO

If yes: ______________________________

*Do you take blood thinners, Warfarin, such as Coumadin, Xarelto? ☐ YES ☐ NO

*Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates? ☐ YES ☐ NO

If yes: ______________________________

*Have you ever been prescribed antibiotic pre-medication for dental treatment? ☐ YES ☐ NO

If yes, what medication? ______________________________

These three questions are incredibly important for the dentist to know.

Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? ☐ YES ☐ NO

Do you use tobacco? ☐ YES ☐ NO If yes, ☐ Cigarettes ☐ Cigar ☐ Chewing Tobacco ☐ Vape

Do you use marijuana? ☐ YES ☐ NO If yes, how often? ______________________________

Do you or have you used controlled substances? ☐ YES ☐ NO

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?

☐ YES ☐ NO

Women only: Are you pregnant? If yes, how many weeks? ______________________________

Are you allergic to any of the following?

☐ Aspirin
☐ Metals (Nickel, Mercury)
☐ Barbiturates, Sedatives, or Sleeping Pill
☐Penicillin
☐ Latex
☐ Iodine
☐ Codeine
☐ Sulfa Drugs
☐ Acrylic
☐ Local Anesthetics like Novocaine

☐ Other If yes: ______________________________

Have you been fully vaccinated for COVID-19? ☐ YES ☐ NO

REVIEW OF SYSTEMS

Do you have or have you ever had the following medical conditions:

Condition		Condition		Condition		Condition	
Aids or HIV Infection	▢ YES ▢ NO	Cortisone Medicine	▢ YES ▢ NO	Hemophile	▢ YES ▢ NO	Radiation Treatments	▢ YES ▢ NO
Alzheimer's Disease	▢ YES ▢ NO	Diabetes	▢ YES ▢ NO	Hepatitis A	▢ YES ▢ NO	Anaphylaxis	▢ YES ▢ NO
Drug Addiction	▢ YES ▢ NO	Hepatitis B or C	▢ YES ▢ NO	Renal Dialysis	▢ YES ▢ NO	Anemia	▢ YES ▢ NO
Easily Winded	▢ YES ▢ NO	Herpes	▢ YES ▢ NO	Rheumatic Fever	▢ YES ▢ NO	Angina	▢ YES ▢ NO
Emphysema	▢ YES ▢ NO	High Blood Pressure	▢ YES ▢ NO	Rheumatism	▢ YES ▢ NO	Arthritis/Gout	▢ YES ▢ NO
Epilepsy or Seizures	▢ YES ▢ NO	High Cholesterol	▢ YES ▢ NO	Scarlett Fever	▢ YES ▢ NO	Artificial Heart Valve	▢ YES ▢ NO
Excessive Bleeding	▢ YES ▢ NO	Hives or Rash	▢ YES ▢ NO	Shingles	▢ YES ▢ NO	Artificial Joint	▢ YES ▢ NO
Excessive Thirst	▢ YES ▢ NO	Hypoglycemia	▢ YES ▢ NO	Sickle Cell Disease	▢ YES ▢ NO	Asthma	▢ YES ▢ NO
Fainting Spells/ Dizziness	▢ YES ▢ NO	Irregular Heartbeat	▢ YES ▢ NO	Sinus Trouble	▢ YES ▢ NO	Blood Disease	▢ YES ▢ NO
Frequent Cough	▢ YES ▢ NO	Kidney Problems	▢ YES ▢ NO	Spina Bifida	▢ YES ▢ NO	Frequent Diarrhea	▢ YES ▢ NO
Leukemia	▢ YES ▢ NO	Stomach/Intestinal Disease	▢ YES ▢ NO	Breathing Problems	▢ YES ▢ NO	Liver Disease	▢ YES ▢ NO
Stroke	▢ YES ▢ NO	Genital Herpes	▢ YES ▢ NO	Low Blood Pressure	▢ YES ▢ NO	Swelling of Limbs	▢ YES ▢ NO
Cancer	▢ YES ▢ NO	Glaucoma	▢ YES ▢ NO	Lung Disease	▢ YES ▢ NO	Thyroid Disease	▢ YES ▢ NO
Chemotherapy	▢ YES ▢ NO	Hay Fever	▢ YES ▢ NO	Mitral Valve Prolapse	▢ YES ▢ NO	Tonsillitis	▢ YES ▢ NO
Chest Pains	▢ YES ▢ NO	Heart Attack/ Failure	▢ YES ▢ NO	Osteoporosis	▢ YES ▢ NO	Tuberculosis	▢ YES ▢ NO
Cold Sores/Fever Blisters	▢ YES ▢ NO	Heart Murmur	▢ YES ▢ NO	Pain in Jaw Joints	▢ YES ▢ NO	Tumors or Growths	▢ YES ▢ NO
Congenital Heart Disorder	▢ YES ▢ NO	Heart Pacemaker	▢ YES ▢ NO	Parathyroid Disease	▢ YES ▢ NO	Ulcers	▢ YES ▢ NO
Convulsions	▢ YES ▢ NO	Heart Trouble/ Disease	▢ YES ▢ NO	Psychiatric Care	▢ YES ▢ NO	Venereal Disease	▢ YES ▢ NO
Yellow Jaundice	▢ YES ▢ NO	Back Problem/ Surgery	▢ YES ▢ NO				

If yes to any of the above, please see next page to elaborate.

History of an eating disorder? ▢ YES ▢ NO If yes: ______________________________

Do you have any disease, condition or problem not listed above? ▢ YES ▢ NO

If yes: ______________________________

PHARMACY

What is the name of your current pharmacy? ____

COMMENTS

If needed, please use this space to elaborate any condition you answered yes to under Review of Systems. For example, "Breast cancer in 2005, now in remission."

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X ____

Signature of Patient or Parent Guardian If Minor

PATIENT MEDICATION LIST

This is often the most important part of the medical history, please be as thorough as possible.

Name: ____ Today's Date: _____________

In order to fill out the form, you need a list of all of your medicines or everything you take in front of you. Be sure you include medicine you take from all pharmacies that you use as well as any over-the-counter medicines, vitamins, herbs or minerals you may take. For every medicine (including ones you get without a prescription), vitamin or herb you take, please write down these things:

- Medication – The name of what you take (like Tylenol, Acetaminophen 500 mg)
- Dosage – How much you take of this (like 1 pill of 150 mg)
- Times/Day – How often you take the medication (like once, twice, three)
- Comments – Add any additional information such as why you take the medication

Medication	Dosage	Times/Day	Comments

Pharmacy: ____

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