

Patient Registration Form

American Dental Association
www.adaa.org

Email:			Today's Date:		
Preferred Name: <input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.			Referred by:		
Name: Last First Middle		Home Phone: include area code ()		Cell Phone: include area code ()	
Address: Mailing address		City:		State: Zip:	
SS#:		Date of Birth:		Sex: M F	
Employer:			Business Phone: include area code ()		
Emergency Contact:		Relationship:		Home Phone: include area code () Cell Phone: include area code ()	
College Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Please provide school info:			School Name: _____		
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired			Address: _____		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Address 2: _____		
Pref. Pharmacy: Phone: ()			City, State, Zip: _____		

Dental Insurance Information

Primary Insurance Information					
Name of Insured: _____			Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Insured Soc. Sec.: _____			Insured Birth Date: _____		
Employer: _____			Ins. Company: _____		
Address: _____			Address: _____		
Address 2: _____			Address 2: _____		
City, State, Zip: _____			City, State, Zip: _____		
ID#: _____ Gr#: _____					
Secondary Insurance Information					
Name of Insured: _____			Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Insured Soc. Sec.: _____			Insured Birth Date: _____		
Employer: _____			Ins. Company: _____		
Address: _____			Address: _____		
Address 2: _____			Address 2: _____		
City, State, Zip: _____			City, State, Zip: _____		
ID#: _____ Gr#: _____					

Dental Information For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure? .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				What was done at that time?			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays:			
What is the reason for your dental visit today?							
How do you feel about your smile?							

Medical Information Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question) Yes No DK	Yes No DK																																																																				
Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Physician Name: _____ Phone: include area code (_____) _____ Address/City/State/Zip: _____	Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what was the illness or problem? _____																																																																				
Are you in good health? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has there been any change in your general health within the past year? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what condition was treated? _____ Date of last physical exam: _____	Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____ Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED																																																																				
Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Are you taking or scheduled to begin taking either of the medications alendronate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date Treatment Began: _____	Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____ WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Number of weeks: _____ Taking birth control pills or hormone replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																																																																				
Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date: _____ If yes, have you had any complications? _____																																																																					
Allergies - Are you allergic to, or have you had a reaction to: Yes No DK To all yes responses, specify type of reaction.																																																																					
Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Barbituates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay fever / seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																																																																				
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Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Name of physician or dentist making recommendation: _____ Phone: (_____) _____ Do you have any disease, condition, or problem not listed above that you think I should know about? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Please explain: _____																																																																					
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. Signature of Patient/Legal Guardian: _____ Date: _____																																																																					