PATIENT REGISTRATION INFORMATION **TODAY'S DATE:**_____

PATIENT NAME_____ DATE OF BIRTH:_____

HOME ADDRESS:_____

SOCIAL SECURITY:_____ HOME PHONE:_____

CELL PHONE:_____ WORK PHONE:_____

DENTIST NAME AND ADDRESS:_____

ARE YOU A STUDENT:_____ SCHOOL NAME AND LOCATION_____

EMPLOYER NAME:_____

EMPLOYER ADDRESS:_____

EMERGENCY CONTACT NAME:_____ RELATIONSHIP:_____

EMERGENCY CONTACT PHONE NUMBER:_____

INSURANCE INFORMATION

DENTAL INSURANCE COMPANY NAME:_____

DENTAL INSURANCE COMPANY ADDRESS:_____

RELATIONSHIP TO INSURED: _____

INSURED'S NAME_____ DATE OF BIRTH:_____

SOCIAL SECURITY:_____ PHONE NUMBER: _____

EMPLOYER ADDRESS:_____ PHONE NUMBER:_____

POLICY ID NUMBER:_____ GROUP NUMBER:_____

MEDICAL INSURANCE COMPANY NAME:_____

MEDICAL INSURANCE COMPANY ADDRESS:_____

RELATIONSHIP TO INSURED: _____

INSURED'S NAME_____ DATE OF BIRTH:_____

SOCIAL SECURITY:_____ PHONE NUMBER: _____

EMPLOYER ADDRESS:_____ PHONE NUMBER:_____

POLICY ID NUMBER:_____ GROUP NUMBER:_____

DENTAL AND MEDICAL HISTORY

DATE OF LAST DENTAL EXAM:_____ DATE OF LAST DENTAL X-RAYS:_____

DENTIST NAME AND ADDRESS:_____

DO YOU HAVE ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY)

__BAD BREATH
__BURNING SENSATION ON TONGUE
__CLICKING OR POPPING OF JAW
__FOOD COLLECTION BETWEEN TEETH
__GUMS SWOLLEN OR TENDER
__LOOSE TEETH OR FILLINGS
__ORTHODONTIC TREATMENT
__SENSITIVITY TO SWEETS
__BLEEDING GUMS
__CHEW ON ONE SIDE OF MOUTH
__DRY MOUTH
__FOREIGN OBJECT
__JAW PAIN AND TIREDNESS
__MOUTH BREATHING
__PAIN AROUND EAR
__SENSITIVITY TO BITING
__BLISTERS ON LIPS/MOUTH
__CIGARETTE, PIPE OR CIGAR SMOKING
__FINGERNAIL BITING
__GRINDING TEETH
__LIP OR CHEEK BITING
__MOUTH PAIN, BRUSHING
__SENSITIVITY TO COLD OR HEAT
__SORES OR GROWTHS IN MOUTH

HOW OFTEN DO YOU BRUSH:_____HOW OFTEN DO YOU FLOSS:_____

DO YOU CURRENTLY HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY)

__AIDS
__ARTIFICIAL HEART VALVE
__BACK PROBLEMS
__CANCER
__CIRCULATORY PROBLEMS
__COUGH, PERSISTENT OR BLOODY
__CONTACT LENSES
__GLAUCOMA
__HEART PROBLEMS
__HIGH BLOOD PRESSURE
__JAUNDICE
__LIVER DISEASE
__NERVOUS PROBLEMS
__RADIATION TREATMENTS
__SCARLET FEVER
__SKIN RASH
__SWELLING OF FEET OR ANKLES
__TONSILS
__ULCER
__ANEMIA
__ARTIFICIAL JOINTS
__ABNORMAL BLEEDING
__CHEMICAL DEPENDENCY
__CONGENITAL TREATMENTS
__DIABETES
__EPILEPSY
__HEADACHES
__HEPATITIS
__HIGH CHOLESTEROL
__JAW PAIN
__LOW BLOOD PRESSURE
__PSYCHIATRIC CARE
__RESPIRATORY DISEASE
__SHORTNESS OF BREATH
__SPECIAL DIET
__SWOLLEN NECK GLANDS
__TUBERCULOSIS
__VENEREAL DISEASE
__ARTHRITIS, RHEUMATIC
__ASTHMA
__BLOOD DISEASE
__CHEMOTHERAPY
__CORTISONE TREATMENTS
__EMPHYSEMA
__FAINTING OR DIZZINESS
__HEART MURMUR
__HERPES
__HIV POSITIVE
__KIDNEY DISEASE
__MITRAL VALVE PROLAPSE
__PACEMAKER
__RHEUMATIC FEVER
__SINUS TROUBLE
__STROKE
__THYROID PROBLEMS
__TUMOR OR GROWTH IN HEAD/NECK
__WEIGHT LOSS, UNEXPLAINED

ANY PREVIOUS SURGERIES:_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:_____

_____

_____

LIST ANY ALLERGIES:_____

_____

PHARMACY NAME AND PHONE NUMBER:_____