

Patient Registration Form

American Dental Association
www.ada.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: _____		Home Phone: <i>include area code</i> () ()		Cell Phone: <i>include area code</i> () ()	
Address: _____ <small>Mailing address</small>		City: _____		State: _____ Zip: _____	
SS#: _____		Date of Birth: _____		Sex: M F	
Employer: _____			Business Phone: <i>include area code</i> () ()		
Emergency Contact: _____		Relationship: _____		Home Phone: <i>include area code</i> () () Cell Phone: <i>include area code</i> () ()	
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? _____							

over

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

<p>(Check DK if you Don't Know the answer to the question) Yes No DK</p> <p>Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Physician Name: _____</p> <p>Phone: <i>include area code</i> (____) _____</p> <p>Address/City/State/Zip: _____</p> <p>Are you in good health? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Has there been any change in your general health within the past year? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, what condition was treated? _____</p> <p>Date of last physical exam: _____</p> <p>Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phenentermine combination)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>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"/></p> <p>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"/></p> <p>Date Treatment Began: _____</p> <p>Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Allergies - Are you allergic to, or have you had a reaction to: Yes No DK To all yes responses, specify type of reaction.</p> <p>Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbituates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Codaine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, what was the illness or problem? _____</p> <p>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"/></p> <p>If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____</p> <p>Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p>WOMEN ONLY Are you:</p> <p>Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormone replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Metals _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (rubber) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever / seasonal _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Animals _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>																																																																
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Yes No DK	Yes No DK	Yes No DK	Yes No DK																																																														
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<p>NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. 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.</p> <p>Signature of Patient/Legal Guardian: _____ Date: _____</p>																																																																	