



Dental Registration

PATIENT INFORMATION

Date _____ SOCIAL SECURITY # _____

Patient Name _____
Last Name First Name Middle Initial

Address _____ City _____ State _____ Zip _____

E-mail _____ Sex (Circle One) M F Age _____ Birthdate _____

Circle One: Married Widowed Single Minor

Patient Employer/School _____ Occupation _____

Employer School/Address _____ Employer School/Phone (_____) _____

Spouse's Name _____ Birthdate _____

Spouse's Employer _____

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____

Cell Phone (_____) _____ Spouse's Work (_____) _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY CONTACT (Specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

Please **circle** referral source:

Friend/Neighbor/Relative
Name: _____

Internet - Google, Bing, etc.
Drove By _____

Facebook

Other _____



Medical History

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 you will receive.

Thank you for answering the following questions!

Are you under a physician's care now?	YES	NO	If yes, please list name _____
Have you ever been hospitalized or had a major operation?	YES	NO	If yes, please explain _____
Have you ever had a serious head or neck injury?	YES	NO	If yes, please explain _____
Are you taking any medications, pills or drugs?	YES	NO	If yes, please explain _____
Do you have any replacement joints such as knee, shoulder, or hip?	YES	NO	If yes, please explain _____
Are you on a special diet?	YES	NO	If yes, please explain _____
Do you use tobacco?	YES	NO	Do you take any medications to treat Osteoporosis such as Fosmax, Aredia, Boniva, or Zometa? YES NO
Do you use controlled substances?	YES	NO	
Are you experiencing pain or discomfort?	YES	NO	Are you taking any blood thinners? NO YES
Are you in good health?	YES	NO	

Women:		Have you ever been diagnosed with infective endocarditis?	NO	YES
Are you pregnant or trying to get pregnant?	YES	NO	Have you ever had heart valve replacement surgery?	NO YES
Nursing?	YES	NO		

Are you allergic to any of the following? (Please Circle)

Aspirin	Penicillin	Codeine	Acrylic	Metal	Latex	Local Anesthetics	Other
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If other, please list _____

Do you have, or have had, any of the following (Please Circle) _____

AIDS/HIV Positive	Cancer	Frequent Diarrhea	Kidney Problems	Sinus Trouble
Alzheimer's Disease	Chemotherapy	Glaucoma	Leukemia	Spina Bifida
Anaphylaxis	Chest Pains	Hay Fever	Liver Disease	Stomach/Intestinal Disease
Anemia	Cold Sores/Fever Blisters	Heart Attack/Failure	Low Blood Pressure	Stroke
Angina	Congenital Heart Disorder	Heart Murmur	Lung Disease	Swelling of Limbs
Arthritis/Gout	Convulsions	Heart Pace Maker	Mitral Valve Prolapse	Thyroid Disease
Artificial Heart Valve	Cortisone Medicine	Heart Trouble/Disease	Pain Jaw Joints	Tonsillitis
Artificial Joint	Diabetes	Hemophilia	Parathyroid Disease	Tuberculosis
Asthma	Drug Addiction	Hepatitis A, B or C	Psychiatric Care	Tumors or Growths
Blood Disease	Emphysema	Herpes	Radiation Treatments	Ulcers
Blood Transfusion	Epilepsy or Seizures	High Blood Pressure	Renal Dialysis	Venereal Disease
Breathing Problem	Fainting Spells/Dizziness	Hypoglycemia	Rheumatic Fever	Yellow Jaundice
Bruise easily	Frequent Cough	Irregular Heartbeat	Rheumatism	