

# Patient Registration Form

Date of Appointment: \_\_\_\_\_

## Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth (Age)		Social Security Number	
Patient's Address			City	State	Zip
Home Phone		Mobile Phone		Email Address	
Referred by		Primary Care Physician		Primary Care Physician Phone	
Pharmacy	Pharmacy Phone		Pharmacy Address		

## Patient Employer/School Information

Employer/School		Occupation	Employer/School Phone		
Employer/School Address			City	State	Zip

## Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient
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## Billing and Insurance

### Primary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School			
Insured's Name (as it appears on insurance card or ID)		Relation to Patient		Insured's Phone Number	
Insured's Address		City	State	Zip	
Insured's Social Security Number	Insured's Birthdate				

### Secondary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School		Insured's Social Security Number	
Insured's Name (as it appears on insurance card or ID)		Relation to Patient		Insured's Phone Number	

### Responsible Party

Billing Name (if other than patient)		Phone	Relation to Patient		
Address		City	State	Zip	

\_\_\_\_\_  
Signature of Patient or Authorized Guardian

\_\_\_\_\_  
Date

Name \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

**Reason for Visit**

What brings you to the office today?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications**

Are you currently taking any blood thinners?

Yes  No

What medications are you currently taking?

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Dental History**

When was your last dental exam?

Date \_\_\_\_\_

When were your last dental x-rays taken?

Date \_\_\_\_\_

How often do you brush?

# times/day \_\_\_\_\_

How often do you floss?

# times/day \_\_\_\_\_

Do you grind your teeth?

Yes  No

Have you ever had orthodontic (braces) treatment?

Yes  No

**Past Medical History**

Have you ever had any of the following?

- Alcoholism
- Allergies
- Anemia
- Anxiety Disorder
- Arthritis
- Asthma
- AIDS / HIV
- Bleeding Disorder
- Blood Disease
- Blood Transfusion
- Bowel Disorder
- Cancer
- Diabetes
- Depression
- Eating Disorder
- Epilepsy
- Hay Fever
- Heart Disease
- Heart Problems
- Hepatitis - A, B, or C
- High Blood Pressure

**Lifestyle Factors**

Have you ever smoked?

Yes  No # of years \_\_\_\_\_ # packs/day \_\_\_\_\_

Do you smoke now?

Yes  No # packs/day \_\_\_\_\_

Do you use recreational drugs?

Yes  No types? \_\_\_\_\_ # times/week \_\_\_\_\_

How much alcohol do you drink per week?

# drinks/week \_\_\_\_\_

How much caffeine do you drink per day?

# drinks/day \_\_\_\_\_

**Allergies**

Are you allergic to any of the following?

- Adhesive Tape
- Barbiturates (Sleeping Pills)
- Codeine
- Antibiotics
- Aspirin
- Sulfa
- Latex
- Iodine
- Local Anesthetics

Do you have any other allergies?

Name	Reaction
_____	_____
_____	_____

**Hospitalizations & Surgeries**

Reason	Date
_____	_____
_____	_____
_____	_____

Have you ever had periodontal (gum) treatments?

Yes  No

Do you have any of the following?

- Bad Breath
- Bleeding Gums
- Blisters on Mouth
- Broken Fillings
- Clicking Jaw
- Dentures
- Difficulty Opening or Closing
- Dry Mouth
- Difficulty Chewing
- Ear Pain
- Jaw Pain
- Loose Teeth
- Mouth Pain
- Mouth Sores
- Partialis
- Sensitivity to Cold
- Sensitivity to Heat
- Sensitivity to Sweets
- Sensitivity to Pressure
- Swollen Gums

**Women Only**

Are you pregnant?

Yes  No

Are you breastfeeding?

Yes  No

What is your method of birth control?

\_\_\_\_\_