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

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

Allergies

Are you allergic to any of the following?

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

Do you have any other allergies?

Name	Reaction

Hospitalizations & Surgeries

Reason	Date

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

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
- ☐ Partials
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity to Pressure
- ☐ Swollen Gums

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
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Lupus
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Skin Disorder
- ☐ Stroke
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease

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 _____

Women Only

Are you pregnant?

☐ Yes ☐ No

Are you breastfeeding?

☐ Yes ☐ No

What is your method of birth control?

_____