Date

PATIENT REGISTRATION

Patient's Name ______________________ Birthdate ____________ Sex ☐ M ☐ F

Patient's Address ______________________ Phone ____________
Street City Zip

Patient's Employer ____________ Business Address ____________ Phone ____________

No. of Yrs. Employed ____ Soc. Sec. No. ____________ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of Spouse ____________ No. of Dependents ______ Spouse's Soc. Sec. No. ____________

Spouse's Employer ____________ Whom May We Thank For Referring You ____________

Nearest Neighbor or Relative's Name, Address, and Phone No. ______________________

Who Will Pay This Account? (Whose Name Will Appear on Billing Statement.)
☐ Self ☐ Spouse ☐ Parent or Guardian

If you Checked "Self" Please Skip Next Section and Continue with Insurance Section

PERSON RESPONSIBLE FOR THIS ACCOUNT OTHER THAN ABOVE NAMED PATIENT

Responsible Party's Name ______________________ Birthdate ____________ Sex ☐ M ☐ F

Street Address (If Dif. Than Above) ______________________ Phone ____________
Street City State Zip

Responsible Party's Employer ____________ No. of Years Employed ____ Soc. Sec. No. ____________

Business Address ______________________ Phone ____________

FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name ____________ Birthdate ____________ Soc. Sec. No. ____________

Subscriber's Employer ____________ Business Address ____________ Insurance Co. ____________

Group No. ____________ Deductible ☐ Yes ☐ No Max. Benefit ____________ Benefit Year ____________

Patients Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent   Have You Used Your Dental Insurance Previously? ☐ Yes ☐ No

Are You Covered Under More Than One Dental Plan? ☐ Yes ☐ No   If Yes, Please Fill Out Next Section.

SECONDARY INSURANCE

Subscriber's Name ____________ Birthdate ____________ Soc. Sec. No ____________

Insurance Co. ____________ Group No ____________ Employer ____________ Relationship to Patient ____________

(Please Continue On Next Page)

FOR OFFICE USE ONLY

Primary Subscriber's Name ______________________ Family Member No. ________ Emp. No. ________

Secondary Subscriber's Name ______________________ Family Member No. ________ Emp. No. ________

Doctor ____________

Medical Message:
1. No Message   2. See Meoical   3. Premedicate   4. See Medical and Premedicate   5. Allergies

MEDICAL HISTORY

General health (please check): Excellent ☐ Good ☐ Fair ☐ Poor ☐

Name and address of physician ______________________________

____

Last complete physical? ______________________________

Are you taking any medication now? Yes ☐ No ☐ For what purpose? ______________________________

Have you ever been treated for:

Heart disease	Yes ☐	No ☐	Heart murmur	Yes ☐	No ☐
Rheumatic fever	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐
Abnormal blood pressure	Yes ☐	No ☐	Asthma or hay fever	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	Sinus trouble	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐	Cough	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Congenital heart lesions	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐
VD (Syphilis, Gonorrhea)	Yes ☐	No ☐	Serious Accident	Yes ☐	No ☐
Aids	Yes__	No__			

Have you ever been treated (other than diagnostic) with x-ray? Yes ☐ No ☐

Are you allergic to: Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other medications ☐ ______________

Are you subject to prolonged bleeding? Yes ☐ No ☐

Are you subject to fainting spells? Yes ☐ No ☐

(Women) Are you pregnant? Yes ☐ No ☐ How long? ______________

DENTAL HISTORY

Date of last dental visit? ______________ Dentist's Name ______________________________ Phone ______________

Did you have x-rays taken? Yes ☐ No ☐

Have you had all your teeth x-rayed in the past 3 years? Yes ☐ No ☐

Do you wear full or partial dentures? Yes ☐ No ☐ (If Yes) How old are they? ______________

Does any member of your family, including your parents, wear dentures? Yes ☐ No ☐

Are you dissatisfied with the appearance of your teeth? Yes ☐ No ☐

Have you had orthodontic treatment? Yes ☐ No ☐

Do you clench or grind your teeth during the day or night? Yes ☐ No ☐

Have you ever had pain in your jaw joint or your face (In and about your ears)? Yes ☐ No ☐

Does your jaw joint click? Yes ☐ No ☐ Do you have difficulty opening your mouth widely? Yes ☐ No ☐

Do you have an unpleasant odor, or taste, in your mouth? Yes ☐ No ☐

Do your gums bleed when brushing? Yes ☐ No ☐ Have you had gum disease or pyorrhea? Yes ☐ No ☐

Is your mouth or teeth sensitive to: Pressure Yes ☐ No ☐ Cold Yes ☐ No ☐ Hot Yes ☐ No ☐

Does food catch between your teeth? Yes ☐ No ☐

Please add anything you feel is important for the doctor to know ______________________________

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We may request / report credit information to T.R.W., a credit rating institution.

Patient's Signature ______________________________