PATIENT REGISTRATION

Name:		
Address:		
City:	Prov:	Postal Code:
Phone (home):	Business:	Cell #:
Email:	Birthdate	
I give consent to contact me by email:	PATIENT SIGNATURE	
Referred by:	Spouse:	

DENTAL INSURANCE

Primary Carrier:	Secondary Carrier:
Employer:	Employer:
Insurance Co:	Insurance Co:
Group#: Birthdate:	Group#: Birthdate:
ID#:	ID#:
A B LIMIT	A B LIMIT

DENTAL HISTORY

1. Are you having pain at this time? yes ❑ no ❑
2. Are any of your teeth sensitive to: cold ❑ sweets ❑ heat ❑ other ❑ ______________
3. Do your gums bleed when: brushing ❑ flossing ❑
4. Have you ever had any of the following (please circle):
   oral surgery, periodontal treatment, orthodontic treatment, bite adjustment, bite plate
   other appliance (specify): ______________________________

	Circle	
5. Have you ever had complications related to dental treatment	yes	no
6. Do you have any dental implants?	yes	no
7. Are you aware of any loose teeth?	yes	no
8. Does food tend to get caught between your teeth?	yes	no
9. Are you satisfied with the appearance of your teeth?	yes	no
10. Are you nervous about having dental treatment?	yes	no

HEALTH HISTORY

PATIENT NAME______________________________

1. Physician's name ______________________________ Phone # ________________

MED ALERT

2. Are you allergic, or have you reacted adversely, to any of the following? Please circle.

   Penicillin Erythromycin Clindamycin Tetracycline Aspirin
   Codeine Sulfa Drugs Darvon Demerol Mint Flavoring
   NSAID's (non Steroidal anti inflammatory drugs) Latex Local Anesthetic

   Other ______________________________

3. Please list all medication you are taking now, including non-prescription medication such as vitamins, cold medications, aspirin, Tylenol, antihistamines, herbal remedies, etc.: ______________________________

   ____

4. Do you have, or have you experienced, any of the following:

Y N Allergies/Hayfever	*Y N* Other Liver Disease	*Y N* Multiple Sclerosis	*Y N* Psychiatric Disorder
Y N Asthma	*Y N* Kidney Disease	*Y N* Parkinson's Disease	*Y N* Glaucoma
Y N Cold Sores	*Y N* Artificial Joints	*Y N* Lupus	*Y N* AIDS/HIV+
Y N Anemia	*Y N* Emphysema	*Y N* Arthritis	*Y N* Epilepsy
Y N Blood Transfusion	*Y N* Tuberculosis (TB)	*Y N* Chronic Fatigue Syndrome	*Y N* High Blood Pressure
Y N Hemophilia	*Y N* Other Lung Disease	*Y N* Sexually Transmitted Disease	*Y N* Scarlet Fever
Y N Hepatitis A (infectious)	*Y N* Ulcerative Colitis	*Y N* Diabetes	*Y N* Rheumatic Fever
Y N Hepatitis B (serum)	*Y N* Crohn's Disease	*Y N* Eating Disorder	*Y N* Thyroid Disease
Y N Hepatitis C	*Y N* Ulcers	*Y N* Drug Addiction	

Heart Disease:

Y N Angina	*Y N* Stroke	*Y N* Heart Murmur
Y N Congestive Heart Failure	*Y N* Mitral Valve Prolapse	*Y N* Artificial Heart Valve/Stent
Y N Angioplasty	*Y N* Pacemaker	*Y N* Cardiopulmonary Shunt
Y N Heart Attack When ________		

Cancer:

Where? ______________________ When? ______________________

Y N Radiation Therapy Y N Chemotherapy

5. Do you have any disease, condition or problem not listed?	yes	no
6. Do you wish to speak privately to the doctor about any medical condition?	yes	no
7. Have you had a medical examination in the last year?	yes	no
8. Have you been a patient in the hospital in the last 2 years?	yes	no
9. When walking up stairs or taking a walk, do you ever stop because of pain in your chest?	yes	no
10. Do your ankles swell during the day?	yes	no
11. Do you have a tendency to faint?	yes	no
12. Do you have frequent, severe headaches?	yes	no
13. Do you use tobacco?	yes	no
14. Are you pregnant or possibly pregnant? If yes, what month? ________	yes	no
15. Are you breast feeding?	yes	no

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

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Patient Signature **Date**