PATIENT REGISTRATION FORM

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Who is your current dentist?_____ **Today's Date:** _____ / _____ / _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Address: _____ City: _____

Address (cont'd): _____ State: _____ Zip: _____

Home Phone: ( ) - _____ Cell Phone: ( ) - _____ DOB: _____ / _____ / _____

Check Appropriate Box:
☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

E-Mail Address (*optional*): _____

If student, name of school: _____ City: _____ State: _____ ☐ Full-Time ☐ Part-Time

Patient or Parent/Guardian's Employer: _____ Work Phone: ( ) - _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Spouse/Parent/Guardian's Name: _____ Employer: _____ Work Phone: ( ) - _____

Emergency Contact: _____ Phone: ( ) - _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____ Relationship: _____

Address: _____ City: _____

Address (cont'd): _____ State: _____ Zip: _____

Home Phone: ( ) - _____ Cell Phone: ( ) - _____ DOB: _____ / _____ / _____

Driver's License #: _____ E-Mail Address (*optional*): _____

SSN #: ___ - ___ - ____ Employer: _____ Work Phone: ( ) - _____

Employer Address: _____ City: _____ State: _____ Zip: _____

We offer the following methods of payment. Please check the option you prefer:
☐ Cash ☐ Personal Check ☐ VISA ☐ MasterCard ☐ Discover ☐ Amex

PATIENT MEDICAL HISTORY FORM

MEDICAL HISTORY

Physician: _____ Office Phone: ( ) - _____ Date of Last Exam: ____ / ____ / ____

Are you under medical treatment now? ☐ Yes ☐ No

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ Yes ☐ No

If yes, please explain: _____

Are you on medication(s), including non-prescription? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No

Have you ever taken any cancer medications? ☐ Yes ☐ No

Have you taken Viagra, Cialis or Levitra in the last 24 hours? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Are you allergic to or have reactions to the following?

- Local Anesthetics ☐ Yes ☐ No
- Antibiotics ☐ Yes ☐ No
- Aspirin ☐ Yes ☐ No
- Ibuprofen ☐ Yes ☐ No
- Tylenol ☐ Yes ☐ No
- Latex Rubber ☐ Yes ☐ No

If not mentioned, please list: _____

Do you have a persistent cough or throat clearing not associated with common illness? ☐ Yes ☐ No

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking oral contraceptives? ☐ Yes ☐ No

Do you have or have you ever had any of the following?

High Blood Pressure	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Chest Pains	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Cardiac Pacemaker	☐ Yes ☐ No	Hay Fever Allergies	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Swollen Ankles	☐ Yes ☐ No	Angina	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Fainting / Seizures	☐ Yes ☐ No	Frequently Tired	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Epilepsy / Convulsions	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Leukemia	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Heart Trouble	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Joint Replacement/Implant	☐ Yes ☐ No	Respiratory Problems	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	Hepatitis / Jaundice	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
AIDS or HIV Infection	☐ Yes ☐ No	STD	☐ Yes ☐ No	Other	☐ Yes ☐ No
Thyroid Problem	☐ Yes ☐ No	Stomach Trouble / Ulcer	☐ Yes ☐ No		

DOCTOR NOTES

Date: ____ / ____ / ____
Doctor: _____
Notes: _____

Date: ____ / ____ / ____
Doctor: _____
Notes: _____

Date: ____ / ____ / ____
Doctor: _____
Notes: _____

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____ Date: ____ / ____ / ____
Signature of Patient (or legal guardian)