

'Patient Registration

First Name - Patient	Middle Name	Last Name - Patient	Nickname/Preferred Name

Patient Date of Birth	Gender	Preferred Language	Social Security Number
	☐ Male ☐ Female ☐ Other		

Patient Mailing Address

Line 1

Line 2

City

State

Zip Code

Country

Home #	Mobile #
() -	() -

Email Address	Driver's License Number

Responsible Party Name	Responsible Party Relationship

Emergency contact	Emergency #
	() -

Occupation	Employer

How did you hear about our Office?

Dental History - (Please check the box if you have/had the following conditions)

☐ Are you currently experiencing dental pain or discomfort?	☐ Do you have earaches or neck pains	☐ Do you have any sores or ulcers in your mouth?	☐ Have you ever had a serious injury to your head, neck, or mouth?
☐ Do your gums bleed when you brush or floss?	☐ Have you had any periodontal (gum) treatment?	☐ Have you had any problems associated with previous dental treatment?	☐ Do you grind your teeth?
☐ Are your teeth sensitive to cold, hot, sweets, or pressure?	☐ Do you have Loose Teeth?	☐ Are you experiencing Bad Breath?	☐ Are you experiencing Dry Mouth?
☐ Smoke/chew tobacco	☐ Oral Surgery	☐ Do you wear dentures or partials	☐ Problems associated with previous dental treatment?

Please detail any Dental Issues checked above

Medical History (Please check the box if you have/had the following conditions)

Allergies

☐ Acetaminophen/Tylenol®	☐ Fluoride	☐ Local anesthetic
☐ Acrylic	☐ Food	☐ Metals
☐ Aspirin	☐ Hay fever/seasonal	☐ Morphine
☐ Codeine	☐ Ibuprofen/Motrin®/Advil®	☐ Penicillin
☐ Demerol	☐ Iodine	☐ Sulfa
☐ Erythromycin	☐ Latex	☐ Tetracycline
☐ Other		

Please elaborate on any reactions you have to the indicated allergies

Conditions

- ☐ Abnormal/excessive bleeding
- ☐ AIDS or HIV infection
- ☐ Alzheimer's/dementia
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Back problems
- ☐ Blood disease
- ☐ Blood Thinners
- ☐ Blood transfusion
- ☐ Breathing problems/respiratory disease
- ☐ Bronchitis
- ☐ Cancer/chemotherapy/radiation treatment
- ☐ Cardiovascular disease
- ☐ Chest pain upon exertion
- ☐ Chronic pain
- ☐ Congestive heart failure
- ☐ Damaged heart valves
- ☐ Diabetes
- ☐ Dizziness
- ☐ Eating disorder
- ☐ Emphysema
- ☐ Other
- ☐ Epilepsy
- ☐ Fainting spells or seizures
- ☐ Fear of Needles
- ☐ Frequent headaches
- ☐ Gastrointestinal disease
- ☐ G.E. Reflux/persistent heartburn
- ☐ Glaucoma
- ☐ Gout
- ☐ Hearing difficulties
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart rhythm disorder
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hepatitis, jaundice or liver disease
- ☐ High blood pressure
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Kidney problems
- ☐ Low blood pressure
- ☐ Low pain tolerance
- ☐ Malnutrition
- ☐ Medications
- ☐ Mitral valve prolapse
- ☐ Multiple Sclerosis
- ☐ Neurological disorders
- ☐ Night sweats
- ☐ Osteoporosis/Paget's disease
- ☐ Other congenital heart defects
- ☐ Pacemaker
- ☐ Persistent swollen glands in neck
- ☐ Physical Challenges
- ☐ Pregnant
- ☐ Pre Medication
- ☐ Psychiatric care
- ☐ Recurrent Infections
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Rheumatism
- ☐ Rheumatoid arthritis
- ☐ Severe headaches/migraines
- ☐ Severe or rapid weight loss
- ☐ Sexually transmitted infection (STI)
- ☐ Sinus trouble
- ☐ Stroke
- ☐ Systemic lupus erythematosus
- ☐ Thyroid problems
- ☐ TMJ
- ☐ TMJ Disorder
- ☐ Tuberculosis
- ☐ Tumors or growths
- ☐ Ulcers

Do you have any disease, condition or problem that is not listed that you think I should know about?

Please detail any Conditions checked above

- ☐ Are you pregnant?

☐ Do you drink alcoholic beverages?
- ☐ Have you ever taken FosaMax®, Boniva®, Actonel®, or other medications containing bisphosphonates?

☐ Have you ever reacted adversely to any medications or injections?
- ☐ Have you had a serious illness, operation, or been hospitalized in the past 5 years?
- ☐ Are you taking any prescription or over-the-counter medicines?
- ☐ Has there been any change to your general health within the past year?
- ☐ Are you currently under the care of a physician?

Print name

Signature

Clear