



**WELCOME REGISTRATION**  
*PERSONAL DATA*

Today's Date: \_\_\_\_\_

Patient Number \_\_\_\_\_

Name: \_\_\_\_\_  
                    First                                    M.I.                                    Last

I prefer to be called: \_\_\_\_\_ Sex: M/F

Birthdate:     /     /     Age:     SS#     /     /

Home Address: \_\_\_\_\_

\_\_\_\_\_

Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_

E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

(   ) Single   (   ) Married   (   ) Divorced   (   ) Widowed

**Dental Insurance**

\_\_\_\_\_ Ins. Co. Name:

\_\_\_\_\_ Address:

\_\_\_\_\_

Ins. Co. Tel. #: \_\_\_\_\_

Group Name: \_\_\_\_\_

Group Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_

\_\_\_\_\_

Work #: \_\_\_\_\_

**Spouse Information**

His/Her Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Birthdate:     /     /     Age:     SS#     /     /

Whom may we thank for referring you? (Please be specific)

1) Friend/Relative \_\_\_\_\_ 2) Doctor \_\_\_\_\_ 3) Web site \_\_\_\_\_

4) Newspaper \_\_\_\_\_ 5) Yellow Pages \_\_\_\_\_ 6) Mailing \_\_\_\_\_ 7) Other \_\_\_\_\_

What is the best way to get in touch with you? \_\_\_\_\_

**DENTAL HISTORY**

Why have you come to the dentist today? \_\_\_\_\_

Are you currently in pain? \_\_\_\_\_

Have you ever had a serious/difficult problem associated with any previous dental work? \_\_\_\_\_

Do you or have you ever had pain/discomfort in your jaw joint (TMJ)? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you clench or grind your teeth while sleeping or during the day? \_\_\_\_\_

Your current dental health is: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Do you like your smile? Yes \_\_\_\_\_ No \_\_\_\_\_ Do your gums ever bleed? Yes \_\_\_\_\_ No \_\_\_\_\_

How many times a week do you floss? \_\_\_\_\_

How many times a day do you brush? \_\_\_\_\_ Type of bristles? Hard \_\_\_ Med \_\_\_ Soft \_\_\_

Last dental visit date: \_\_\_\_\_ Last dental x-rays \_\_\_\_\_

Are you interested in replacing any missing teeth? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you presently wear any removable bridges or dentures? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you interested in doing away with your removable dentures? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you interested in the benefits of nutritional supplementation? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you nervous about your dental treatment? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, have you had nitrous oxide or

medication prior to treatment Yes \_\_\_\_\_ No \_\_\_\_\_

Please add anything you feel is important: \_\_\_\_\_

Doctor's Dental Note: \_\_\_\_\_

\_\_\_\_\_

**Medical History**

Your current general health is ( ) Good ( ) Fair ( ) Poor

Are you currently under the care of a physician? ( ) Yes ( ) No

Please explain: \_\_\_\_\_

Name, address & Phone of physician \_\_\_\_\_

Last complete physical \_\_\_\_\_

Are you taking any prescription/over-the-counter drugs? ( ) Yes ( ) No

Please list each one: \_\_\_\_\_

Do you normally medicate prior to your hygiene or dental visit? \_\_\_\_\_

With what medication? \_\_\_\_\_

Have you ever had any of the following diseases or medical problems:

- |   |   |                           |   |   |                                   |
|---|---|---------------------------|---|---|-----------------------------------|
| Y | N | Heart Attack/Stroke       | Y | N | Psychiatric Problems              |
| Y | N | Cancer/Chemotherapy       | Y | N | Epilepsy/Seizures/Fainting Spells |
| Y | N | Heart Murmur              | Y | N | Diabetes/Tuberculosis (TB)        |
| Y | N | Rheumatic Fever           | Y | N | Drug/Alcohol Abuse                |
| Y | N | HIV+                      | Y | N | Venereal Disease                  |
| Y | N | AIDS                      | Y | N | Hemophilia/Abnormal Bleeding      |
| Y | N | Heart Surgery/Pacemaker   | Y | N | Ulcers/Colitis                    |
| Y | N | Shingles                  | Y | N | Congenital Heart Defect           |
| Y | N | Mitral Valve Prolapse     | Y | N | Anemia/Radiation Treatment        |
| Y | N | Kidney Problems           | Y | N | Asthma/Arthritis                  |
| Y | N | Artificial Valves/Joints  | Y | N | Difficulty Breathing              |
| Y | N | Sinus Problems            | Y | N | Hospitalized for any reason       |
| Y | N | High/Low Blood Pressure   | Y | N | Blood Transfusion                 |
| Y | N | Chest Pains               | Y | N | Hepatitis                         |
| Y | N | Severe/Frequent Headaches | Y | N | Smoking                           |
| Y | N | Liver Problems            | Y | N | Chest Pains                       |

Please list any medical condition(s) that you have ever had: \_\_\_\_\_

Are you allergic to any of the following drugs?

- |   |   |             |   |   |                    |
|---|---|-------------|---|---|--------------------|
| Y | N | Penicillin  | Y | N | Dental Anesthetics |
| Y | N | Aspirin     | Y | N | Codeine            |
| Y | N | Other _____ |   |   |                    |

Do you have a history of cold sores, fever blisters or cankers sores? ( ) Yes ( ) No

Have you ever been tested for hepatitis? ( ) Yes ( ) No

For Women: Are you taking birth control pills? ( ) Yes ( ) No

Are you pregnant ( ) Yes ( ) No Week #: \_\_\_\_\_

Are you nursing? ( ) Yes ( ) No

In the event of emergency, who do you give permission for us to contact?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Work #: \_\_\_\_\_ Home #: \_\_\_\_\_

Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Can we leave a message? ( ) Yes ( ) No

**Consent:**

The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patients' dental or oral-facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents.

\_\_\_\_\_  
Patient Signature (or Parent signature if Child is minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

\_\_\_\_\_  
Date