PATIENT REGISTRATION INFORMATION

Patients Name ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Separated ☐ Widowed

Social Security # | Date of Birth | Cell Phone | Home Phone | Business Phone

Address | City | State | Zip

Employed By | Email Address

Spouse/Partner's Name | Social Security # | Date of Birth

Spouse/Partner's employed by

Best Form of Contact?

☐ Home ☐ Work
☐ Cell ☐ Email

EMERGENCY CONTACT/NEAREST RELATIVE

Name | Phone

Address | City | State | Zip

DENTAL INSURANCE

Name of Dental Insurance | Group Number | Member ID #

Spouse/Partner's Dental Insurance | Group Number | Member ID #

PARTY RESPONSIBLE FOR PAYMENT:

Check all that applies for Payment: ☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit

Referred By | Address

Due to the increased cost of mailing statements and in trying to keep our fees as low as possible, we find it necessary to expect our patients to pay for service at the time they are rendered, unless prior arrangements have been made by our receptionist or business assistant. Until arrangements are made, we will expect payment each time we see you. We want to give you the best and most reasonable service possible without having to raise our fees and will appreciate your cooperation in this matter.

I FULLY UNDERSTAND AND AGREE TO THE ABOVE POLICY.

Patient Signature | Date

7/15/2013

HEALTH HISTORY

FOR YOUR WELFARE AND OUR EFFICIENCY OF DIAGNOSIS AND TREATMENT, PLEASE FILL IN THE FOLLOWING *CONFIDENTIAL* FORM COMPLETELY, PLEASE ANSWER ALL QUESTIONS.

Name: ______________________ Name of Physician: ______________________

Date of Birth: ______________________ Age: ______________________

☐ High Blood Pressure	☐ Diabetes	☐ Mitral Valve Prolapse	☐ Stomach Ulcer
☐ Any Heart Problems	☐ Epilepsy	☐ Emphysema	☐ Nervous Problems
☐ Rheumatic Fever	☐ Hepatitis or Liver Disease	☐ Arthritis	☐ Psychiatric Care
☐ Low Blood Pressure	☐ Kidney Problems	☐ Glaucoma	☐ Asthma or Hay Fever
☐ Circulatory Problems	☐ Night Sweats	☐ Mouth Ulcers	☐ Radiation/Xray Treatment
☐ Stroke	☐ Tuberculosis	☐ Anemia	☐ Joint Replacement Surgery
☐ Cancer or Tumor	☐ Hormone Disorder	☐ Sinus Problems	☐ Other

1. **HOW IS YOUR GENERAL HEALTH?** ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
2. Do you have or have you had any of the following, please indicate with check mark.
3. Are you being treated by a physician now? ☐ YES ☐ NO
   If yes, please give reason for treatment ______________________
4. Are you allergic to Latex Penicillin, Codeine or aspirin? ☐ YES ☐ NO
5. Are you subject to prolonged or excess bleeding? ☐ YES ☐ NO
6. Females: Are you pregnant? ☐ YES ☐ NO
7. What types of medications are you taking? ______________________
   For what purpose? ______________________
8. Have you had any serious illness or operation in the last 5 years? ☐ YES ☐ NO
9. Approximate date of last dental visit? ______________________
10. Approximate date when teeth were last cleaned? ______________________
11. How often do you floss your teeth? ______________________
12. Do your gums ever bleed while brushing? ☐ YES ☐ NO
13. Does food catch between your teeth? ☐ YES ☐ NO
14. Do your gums ever feel tender or swollen? ☐ YES ☐ NO
15. Does heat, cold, or sweets cause pain in your mouth? ☐ YES ☐ NO
16. Do you clench your teeth during the day or night? ☐ YES ☐ NO
17. Have you ever been treated for “Trench Mouth” or Gum Disease? ☐ YES ☐ NO
18. Have you ever had Periodontal Treatments or Gum Surgery? ☐ YES ☐ NO
19. Have you had any DIFFICULT extractions in the past? ☐ YES ☐ NO
20. Have you lost any teeth? ☐ YES ☐ NO
21. Have they ever been replaced by: ☐ Fixed Bridge ☐ Removable Partial Denture ☐ Implant
22. Do you have any other disease, condition or problem not listed above that you think I should know about?

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DATE ______________________ SIGNATURE ______________________