

Patient Registration Form

American Dental Association
www.ada.org

| | | | | | |
|--|--|--|--|---|-------------------------|
| Email: _____ | | | Today's Date: _____ | | |
| Preferred Name: <input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. | | | Referred by: _____ | | |
| Name: _____ | | Home Phone: <i>include area code</i> () | | Cell Phone: <i>include area code</i> () | |
| Last First Middle | | | | | |
| Address: _____ | | | City: _____ | | State: _____ Zip: _____ |
| Mailing address | | | | | |
| SS#: _____ | | Date of Birth: _____ | | Sex: M F | |
| Employer: _____ | | | Business Phone: <i>include area code</i> () | | |
| Emergency Contact: _____ | | Relationship: _____ | | Home Phone: <i>include area code</i> () Cell Phone: <i>include area code</i> () | |
| College Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time | | | Please provide school info: _____ | | School Name: _____ |
| Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired | | | Address: _____ | | |
| Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed | | | Address 2: _____ | | |
| Pref. Pharmacy: _____ Phone: () | | | City, State, Zip: _____ | | |

Dental Insurance Information

| | |
|--|--|
| Primary Insurance Information | |
| Name of Insured: _____ | Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other |
| Insured Soc. Sec.: _____ | Insured Birth Date: _____ |
| Employer: _____ | Ins. Company: _____ |
| Address: _____ | Address: _____ |
| Address 2: _____ | Address 2: _____ |
| City, State, Zip: _____ | City, State, Zip: _____ |
| ID#: _____ Gr#: _____ | |
| Secondary Insurance Information | |
| Name of Insured: _____ | Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other |
| Insured Soc. Sec.: _____ | Insured Birth Date: _____ |
| Employer: _____ | Ins. Company: _____ |
| Address: _____ | Address: _____ |
| Address 2: _____ | Address 2: _____ |
| City, State, Zip: _____ | City, State, Zip: _____ |
| ID#: _____ Gr#: _____ | |

Dental Information For the following questions, mark (X) your responses to the following questions.

| | Yes | No | DK | | Yes | No | DK |
|--|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| Do your gums bleed when you brush or floss? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have earaches or neck pains? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your teeth sensitive to cold, hot, sweets or pressure? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any clicking, popping or discomfort in the jaw? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your mouth dry? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you brux or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any periodontal (gum) treatments? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have sores or ulcers in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had orthodontic (braces) treatments? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear dentures or partials? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any problems associated with previous dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you participate in active recreational activities? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your home water supply fluoridated? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a serious injury to your head or mouth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink bottled or filtered water? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Date of your last dental exam: _____ | | | |
| If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY | | | | What was done at that time? _____ | | | |
| Are you currently experiencing dental pain or discomfort? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Date of last dental x-rays: _____ | | | |
| What is the reason for your dental visit today? _____ | | | | | | | |
| How do you feel about your smile? _____ | | | | | | | |

Medical Information Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

| (Check DK if you Don't Know the answer to the question) Yes No DK | Yes No DK |
|--|--|
| Are you now under the care of a physician? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Physician Name: _____ Phone: <i>include area code</i> (_____) _____ Address/City/State/Zip: _____ | Have you had a serious illness, operation or been hospitalized in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what was the illness or problem? _____ |
| Are you in good health? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has there been any change in your general health within the past year? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, what condition was treated? _____ | Are you taking or have you recently taken any prescription or over the counter medicine(s)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____ _____ |
| Date of last physical exam: _____ | Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED |
| Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____ |
| Are you taking or scheduled to begin taking either of the medications alendronate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | WOMEN ONLY Are you: |
| Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date Treatment Began: _____ | Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Number of weeks: _____ Taking birth control pills or hormone replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)?
Date: _____ If yes, have you had any complications? _____

Allergies - Are you allergic to, or have you had a reaction to: **Yes No DK**
To all **yes** responses, specify type of reaction.

| | |
|--|---|
| Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Barbituates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Hay fever / seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| | Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |

| Yes No DK | Yes No DK | Yes No DK | Yes No DK |
|---|--|---|--|
| Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | If yes, specify: _____ |
| Artificial heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | If yes, date: _____ | Diabetes Type I or II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | AIDS or HIV infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | If yes, specify: _____ |
| Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Recurrent infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | G.E. Reflux/Persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Type of infection: _____ |
| Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Coronary artery disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Hepatitis, jaundice or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Severe headaches/ Migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Sexually transmitted disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Cancer/Chemotherapy/ Radiation treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | |
| Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | |

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
Name of physician or dentist making recommendation: _____ Phone: (_____) _____
Do you have any disease, condition, or problem not listed above that you think I should know about?
Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
Signature of Patient/Legal Guardian: _____ Date: _____