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Family & Cosmetic Dentistry

PATIENT REGISTRATION

Phone: _____

Cell: _____

Email: _____

Date: _____

Patient: _____
(Last Name) (First Name) (Initial) (Preferred Name)

Street Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Age: ___ Birthdate: _____ Single Married Widowed Separated Divorced

Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Spouse Name: _____ Spouse Birthdate: _____

Spouse Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Social Security Number: _____ Spouse's Social Security Number: _____

Dental Insurance Company: _____ Member ID #/Group Number: _____

In case of emergency, who should be notified? _____ Phone: _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Physical: _____

Have you ever had any of the following? (Check boxes that apply):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Special Diet | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Swollen Neck Glands | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> "A.I.D.S" or Other Immunosuppressive Disorders | |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Murmur-Mitral Valve |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Allergies to Medicine or Drugs | <input type="checkbox"/> Ulcer | Prolapse |

Back Problems

General Allergies

Diabetes

Do you have any **drug allergies** or have you ever had an **adverse reaction** to any medication? _____ If so, what:

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what: _____

Are you under the care of a physician? Yes No

For what conditions? _____

If the patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? Yes No

Are you nursing? Yes No

Is there anything else we should know about your medical history? _____

DENTAL HISTORY

Date of last dental exam? _____ Date of last full mouth series? _____

What is the reason for today's visit? _____

If there was a simple inexpensive way to whiten your teeth, would you be interested? _____

If you could wave a magic wand and change one thing about your smile, what would it be? _____

Why did you leave your last dentist? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have in the completion of this form.

Patient Name: _____ Signature: _____ Date: _____