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PATIENT REGISTRATION FORM

Welcome to our office. In order to begin treatment, the following information is necessary. Please complete these forms fully. All information will be held in strict confidence.

PERSONAL INFORMATION

Patient Name: _____ How do you wish to be called: _____
Address: _____ City, State, Zip Code: _____
Home Phone Number: (___)_____ Work Phone Number: (___) _____
Cell Phone Number: (___)_____ Email: _____
Birthday: _____ Age: ____ Male/ Female Married/ Single/ Divorced /Widowed
Social Security Number: _____
Employer's Name: _____ Occupation: _____
Employer's Address. _____
Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Phone Number: (___)_____
Address: _____ Group Number: _____
If other than patient, Insured's Name: _____
Insured's Social Security Number: _____ Insured's Birthday: _____
Insured's Employer's Name_____
Insured's Relationship to Patient: (please circle) Self/ Spouse/ Parent / Other _____

Secondary Insurance Company: _____ Phone Number: (___)_____
Address: _____ Group Number: _____
If other than patient, Insured's Name: _____
Insured's Social Security Number: _____ Insured's Birthday: _____
Insured's Employer's Name _____
Insured's Relationship to Patient: (please circle) Self/ Spouse/ Parent / Other _____

EMERGENCY INFORMATION

Person to contact in an emergency: _____ Relationship:_____
Address: _____ Phone Number: (___)_____

HEALTH HISTORY

Please answer all questions	YES	NO
1. Are you under a physician's care now?	____	____
2. Have you been hospitalized or had a serious illness within the past 5 years?	____	____
3. Date of last Medical Examination: _____		
4. Are you pregnant? _____ Month: _____		
5. Are you taking any medications or drugs at present? If yes, what? _____	____	____

Do you now have or have you ever had any of the following

1. Y N Heart Disease, congenital heart defect
2. Y N Heart murmur/mitral valve prolapse
3. Y N Pacemaker
4. Y N Stroke
5. Y N Rheumatic Fever
6. Y N High blood pressure
7. Y N Anemia
8. Y N Thyroid problem
9. Y N Diabetes
10. Y N Prolong bleeding disorder
11. Y N Kidney disease
12. Y N Asthma
13. Y N Tuberculosis or emphysema
14. Y N Fainting spells ,epilepsy or seizures
15. Y N Psychiatric problems
16. Y N Liver disease
17. Y N Hepatitis Type __
18. Y N Arthritis
19. Y N Tumor or Malignancy
20. Y N Chemotherapy
21. Y N Radiation Treatment
22. Y N Sexually transmitted/ Venereal Disease
23. Y N Glaucoma
24. Y N Immunosuppressive disorder (HIV, AIDS)
25. Y N Sinus problem
26. Y N Joint surgery or prosthetic joint replacement
27. Y N Do you smoke or use tobacco?
28. Y N Have you ever taken Fen-Phen or Redux
29. Y N Have you ever taken Fosamax,Boniva,Actonel, Reclast or other bisphosphonates
30. Y N Allergy to Latex

Are you allergic to any medications? If so, please list_____
Is there anything of importance in your medical history that has not been asked? _____
Please explain: _____
Physicians Name: _____Phone Number: (____)_____
Address: _____ If Kaiser, Medical-Number:_____

Update

Any changes in your health? Y N _____Any medications not listed ?_____
Signature _____Date _____ Staff _____

Any changes in your health? Y N _____Any medication not listed?_____
Signature _____Date _____ Staff _____

Any changes in your health? Y N _____ Any medication not listed? _____
Signature _____Date _____ Staff_____

DENTAL HISTORY

Name of former Dentist: _____ Phone Number: (__)_____
Address: _____
How long since your last exam and X-ray? _____Cleaning? _____
What is the primary purpose for this visit? _____
Were you satisfied with your past dentistry? _____
How often do you brush your teeth? _____ Floss? _____
Have you ever had any of the following:
Orthodontics _____ Oral Surgery _____ Periodontal Surgery _____ Root Canal_____
Do you have any of the following:
Bleeding gums _____ Sensitive gums _____ Sensitive teeth _____ Dry mouth _____
Pain on chewing _____ Bad breath _____ Jaw joint noises or problems _____
Do you have any problems with dental anesthetic? _____
Are you happy with the appearance of your smile? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I will also inform my Dentist of any change in my health or medication.

Signature: _____ Date: _____

Consent

Minor
I, being the Parent (or Guardian) of the above named minor patient, hereby authorize the performance of dental services upon this patient and whatever procedures that the judgment of the doctor may dictate in order to carry out treatment procedures as outlined on the treatment plan form. I also authorize the administration of anesthetics as may be deemed advisable by the doctor.
Signature_____ Relationship_____

Adult
I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics or X-rays as may be deemed necessary by the doctor.
Signature_____ Date_____