MY FAMILY DENTAL

Patient Registration Information Form

Date: _____ Driver's License # _____

Patient Name _____ M ◯ F ◯ Birth Date _____ Age _____

Parent and or Guardian Name _____

Address _____ City _____ Zip Code _____

Home Phone Number _____ Work Phone Number _____(ext) _____

Cell Phone Number _____ E-Mail Address _____

Social Security Number _____ ❑ Minor ❑ Single ❑ Married ❑ Widowed

Employed By: _____Occupation_____

Spouse Name: _____Spouse Birth Date_____

Spouse Employed By: _____Occupation_____

Spouse Social Security Number: _____

Person to contact in emergency _____ Phone _____

Do you have Dental Insurance? Yes◯No◯ Does your Spouse? Yes◯No◯

Name or your dental carrier? _____ Name of Spouse dental carrier? _____

How Did You Find Out About Our Office: (Circle Number)

1. Referred By Patient. Who _____ **2.** Newspaper. Which?_____

3. Office Sign **4.** Internet **5.** Yellow Pages. Which One? _____

6. Referred by one of our employees. Who? _____ **7.** Other Source? _____

If Student, Name of School/College - Full or Part Time (circle one) _____

METHOD OF PAYMENT

Please check on of the following:

_____ Payment in full at each appointment

_____ Co-payment in full at each appointment

_____ Credit Card

_____ Debit Card

Patient Signature_____
(Parent or Guardian)

Dental History

Last Dental Visit was on _____ Reason _____

Were x-rays taken? Yes No

Previous Dentist _____ Phone Number _____

Why did you leave your last dental practice? _____

How do you react to Dental Care? Dread it _____ Worry about it _____ Don't mind it _____

By asking these questions we will be able to better understand your previous dental experiences, your dental concerns and dental goals, short term and long term.

Please, help us understand your daily oral hygiene care, please check appropriate boxes

❑ Manual Tooth Brush	❑ Electric Tooth Brush	❑ Floss	❑ Floss Threader
❑ Proxabrush	❑ Waterpik	❑ Rubber Tip	❑ Stimudents
❑ Fluoride gel / rinses	❑ Mouth Wash	❑ Tongue Scraper	❑ Other

How often do you brush? ❑ 1x daily ❑2x daily ❑3x daily

YES	NO	Please check appropriate box:
❑	❑	Are you experiencing pain or discomfort from your mouth at this time? If so, where? Lower Right Lower Left Upper Right Upper Left
❑	❑	Are there any areas in your mouth that are sensitive to hot/cold/sweet? If so, where? Lower Right Lower Left Upper Right Upper Left
❑	❑	On a scale from one to ten how would you rate your smile (ten is the best) 1❑2❑3❑4❑5❑6❑7❑8❑9❑10❑
❑	❑	Would you like to know about the different types of cosmetic options available to you in dentistry?
❑	❑	Have you noticed any loose teeth or change in your bite?
❑	❑	Have you noticed any soreness or tenderness on your gum tissue at times?
❑	❑	Do you ever notice any bleeding of your gum tissue when you are brushing your teeth?
❑	❑	Do you experience a bad taste in your mouth during the daytime hours?
❑	❑	Are you aware of any lumps in your mouth?
❑	❑	Do you find yourself avoiding some foods because they may get caught between your teeth?
❑	❑	Do you clench or grind your teeth in the daytime or night?
❑	❑	Do your jaws feel tired after eating? After you wake up in the morning? YES❑ NO❑
❑	❑	Do you ever hear popping or clicking sounds when you chew? If so, where? _____
❑	❑	Have you had a night guard made for you?
❑	❑	Do you wear partials or dentures? If so, how old are they? _____
❑	❑	Have you ever had prolonged bleeding following extractions in the past?
❑	❑	Would you be interested in having straighter teeth without involving orthodontics/braces?

If there are any concerns not listed above, let us know below: _____

_____

_____

_____

_____

Medical History

Are you under the care of a physician? _____ If yes, Condition _____

‹ When was your last physical examination? _____

‹ Have you been hospitalized or had a serious illnes within the last five years? _____ If yes, what was the problem? _____

‹ _____

‹ Have you been advised by a physician to pre-medicate with an antibiotic prior to having dentistry? Yes No

‹ Physician _____ Phone _____

List of current medication **Reasons**

_____

_____

_____

_____

Are you allergic to, or have had any unusual reactions to any of the following:

Yes	No		Yes	No		Yes	No	
○	○	Dental Anesthetic	○	○	Metronidazole	○	○	Aspirin
○	○	Penicillin	○	○	Codeine	○	○	Latex
○	○	Erythromycin	○	○	Sulfa Drugs	○	○	Other

Do you Have or have you ever had any of the following? (Please check appropriate conditions)

Yes	No		Yes	No		Yes	No	
○	○	Heart Trouble/ Disease	○	○	Kidney Disease	○	○	Hypoglycemia
○	○	Heart Attack/ Failure	○	○	Arthritis/ Gout	○	○	Artificial Joints/Pins/ Plates
○	○	Irregular Heart Beat	○	○	Rheumatism			
○	○	Angina/Chest Pain	○	○	Thyroid Disease	○	○	Dental Implants
○	○	Congenital Heart Disorder	○	○	Epilepsy/ Seizures	○	○	Bruise Easily
○	○	Mitral Valve Prolapse	○	○	Glaucoma	○	○	Venereal Disease
○	○	Heart Murmur	○	○	Tumors/ Growths	○	○	Aids/HIV
○	○	Artificial Heart Valves	○	○	Hepatitis A Infectious	○	○	Ulcers
○	○	Rheumatic Fever	○	○	Hepatitis B Infectious	○	○	Radiation Therapy
○	○	Scarlet Fever	○	○	Hepatitis C	○	○	Cortisone/Hormonal therapy
○	○	High Blood Pressure	○	○	Hepatitis D			
○	○	Low Blood Pressure	○	○	Hepatitis E	○	○	Do you smoke? ____per day
○	○	Stroke	○	○	Liver Disease			
○	○	Tuberculosis	○	○	Jaundice	○	○	Do you use smokeless tobacco?
○	○	Sickle Cell Disease	○	○	Diabetes			
○	○	Hemophilia (Bleeding Problem)			❑ Controlled	○	○	Use presciption diet pills
○	○	Anemia			❑ Uncontrolled	○	○	Alcohol Abuse
○	○	Emphysema	○	○	Insulin Dependent	○	○	Drug Addiction
○	○	Asthma	○	○	Osteoporosis	○	○	Psychiatric Care
			○	○	Cancer	○	○	Nervousness
			○	○	Chemo Therapy	○	○	Alzheimer's Diseas
			○	○	Have you taken Zometa	○	○	Night Sweats

Do you have any disease, conditions or other problems I should know about, not listed above?

_____

Women Only Are you Pregnant? _____ If so, how many months? _____ Due Date _____

To the best of my knowledge, all the proceeding answers are correct. If I have any changes in my heath status or if my medicines change, I shall inform the dentist and staff at the next appointment.

_____ Date: _____

Patient Signature (Parent or Guardian)

_____

FOR OFFICE USE ONLY

Hard and Soft Tissue Oral Cancer Exam

Normal _____ **Abnormal** _____ **If abnormal, give description** _____

_____

Dentist Signature Date Hygienist Signature Date

HIPPA Form Signed _____

Additional Information

Medical Update	Signature	Medical Update	Signature