ADULT REGISTRATION

Please fill in your answers as thoroughly as possible. All information will be held in confidence.

1 About You

Today's Date: _____

Chart Updated: _____

Name: _____
LAST FIRST MI. MR. MRS. MS.

☐ Male ☐ Female

Birthdate: _____ Age _____ SS #: _____

Home Address: _____
APT/CONDO #

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: _____ Pager/Other #: _____

Wk: #: _____ Ext.: _____

Employer: _____

Employer's Address: _____

_____
CITY STATE ZIP

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Present Dentist: _____

2 Spouse Information

His/Her Name: _____

Employer: _____

Employer Address: _____

_____
CITY STATE ZIP

Hm#: _____ Wk#: _____ Ext.: _____

SS #: _____

Person Responsible for Account:

Wk #: _____ Ext.: _____ Hm #: _____

Billing Address: _____

_____
CITY STATE ZIP

Relation: _____ SS #: _____

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____

4 Medical Insurance

Primary Medical Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____

Secondary Medical Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____

B
FRONT

ADULT REGISTRATION

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in dental offices always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of your previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, pills or drugs? What? _____ Ever taken Fen-phen?* _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No

Do you have or have you ever had any of the following? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐	Cold Sores
☐	☐	Heart Murmur*	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐	Fever Blisters
☐	☐	Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐	Herpes
☐	☐	Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	X-Ray Treatments(Radiation)	☐	☐	Thyroid Disease	☐	☐	Stroke
☐	☐	Heart Attack/Failure	☐	☐	Hemophilia(Bleeding Problem)	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐	Convulsions
☐	☐	Congenital Heart Disease	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐	Epilepsy or Seizures
☐	☐	Mitral Valve Prolapse*	☐	☐	Recent Blood Transfusion	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐	Fainting or Dizziness
☐	☐	Scarlet Fever	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss	☐	☐	Pain In Jaw Joints	☐	☐	Glaucoma
☐	☐	Rheumatic Fever*	☐	☐	Lung Disease	☐	☐	Frequent Diarrhea	☐	☐	Cortisone Medicine	☐	☐	Tumors or Growths
☐	☐	Artificial Heart Valve*	☐	☐	Breathing Problem	☐	☐	Diabetes	☐	☐	Artificial Joint*	☐	☐	Nervousness
☐	☐	Heart Pace Maker*	☐	☐	Shortness of Breath	☐	☐	Excessive Thirst	☐	☐	Venereal Disease	☐	☐	Psychiatric Care
☐	☐	Heart Surgery	☐	☐	Frequent Cough	☐	☐	Hypoglycemia	☐	☐	AIDS	☐	☐	Alzheimer's Disease
☐	☐	High Blood Pressure	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	HIV Positive	☐	☐	Allergies(Medicines)
☐	☐	Low Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A(Infectious)	☐	☐	Genital Herpes	☐	☐	Allergies(Pollen/ Dust)
☐	☐	Blood Disease	☐	☐	Asthma	☐	☐	Hepatitis B or C	☐	☐	Drug Addiction/Alcoholism	☐	☐	Hives or Rash
☐	☐	Unexplained Fever	☐	☐	Bloody Sputum	☐	☐	Night Sweats	☐	☐	Tattoos	☐	☐	Need Premedication?

Have you ever had and other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____

History Review and Significant Findings _____

ADULT REGISTRATION

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____