PATIENT REGISTRATION INFORMATION

_ Single Married Life Partner Divorced Separated Widowed

Patient's Name

_ _____ _____ _____ _____

Social Security Number Date of Birth Cell Phone Home Phone Business Phone

_ _____ _____ _____

Address City State Zip

_ _____

Employed by: Email Address

_ _____ _____

Spouse/Partner's Name Social Security Number Date of Birth

_ Best Form of Contact? Home ( ) Work ( )

Spouse/Partner's employed by Cell ( ) Email ( )

EMERGENCY CONTACT/NEAREST RELATIVE

_ _____

Name Phone

_____ _____

Address City State Zip

DENTAL INSURANCE

_ _____ _____

Name of your Dental Insurance Company Group Number Member ID #

_ _____ _____

Name of your Spouse/Partner's Dental Insurance Company Group Number Member ID #

PARTY RESPONSIBLE FOR PAYMENT: _____

Circle all that applies for Payment: CASH CHECK Credit Card Care Credit

_ _____

Referred by Address

Due to the increased cost of mailing statements and in trying to keep our fees as low as possible, we find it necessary to expect our patients to pay for service at the time they are rendered, unless prior arrangements have been made by our receptionist or business assistant. Until arrangements are made, we will expect payment each time we see you. We want to give you the best and most reasonable service possible without having to raise our fees and will appreciate your cooperation in this matter.

I FULLY UNDERSTAND AND AGREE TO THE ABOVE POLICY.

_____ _____

Patient Signature Date

PLEASE COMPLETE BACK PAGE

HEALTH HISTORY

FOR YOUR WELFARE AND OUR EFFICIENCY OF DIAGNOSIS AND TREATMENT, PLEASE FILL IN THE FOLLOWING ***CONFIDENTIAL*** FORM COMPLETELY. PLEASE ANSWER ALL QUESTIONS.

Name_____ **Name of Physician**_____

Date of Birth_____ **Age**_____

Please check all that apply:

____High Blood Pressure	____Diabetes	____Joint Replacement Surgery	____Radiation(Xray) Treatment
____Any Heart Problems	____Epilepsy	____Mitral Valve Prolapse	____Nervous Problems
____Rheumatic Fever	____Hepatitis or Liver Disease	____Emphysema	____Psychiatric Care
____Low Blood Pressure	____Kidney Problems	____Arthritis	____Sinus Problems
____Circulatory Problems	____Night Sweats	____Glaucoma	____Asthma or Hay Fever
____Stroke	____Tuberculosis	____Mouth Ulcers	____Stomach Ulcer
____Cancer or Tumor	____Hormone Disorder	____Anemia	____Other

1. **HOW IS YOUR GENERAL HEALTH? (Please Circle) EXCELLENT GOOD FAIR POOR**
2. **Do you have or have you had any of the following, please indicate with check mark.**
3. **Are you being treated by a physician now?**_____

   If yes, please give reason for treatment _____

   _____
4. **Are you allergic to Latex, Penicillin, Codeine or aspirin?** _____
5. **Are you subject to prolonged or excessive bleeding?** _____
6. **Females: Are you pregnant?**_____
7. **What types of medications are you taking?** _____

   For what purpose? If you have a list offer to us we'll copy it. _____
8. **Have you had any serious illness or operation in the last 5 years?**_____
9. **Approximate date of last dental visit?**_____
10. **Approximate date when teeth were last cleaned**_____
11. **How often do you floss your teeth?**_____
12. **Do your gums ever bleed while brushing?**_____
13. **Does food catch between your teeth?**_____
14. **Do your gums ever feel tender or swollen?**_____
15. **Does heat, cold, or sweets cause pain in your mouth?**_____
16. **Do you clench your teeth during the day or night?**_____
17. **Have you ever been treated for "Trench Mouth" or Gum Disease?**_____
18. **Have you ever had Periodontal Treatments or Gum Surgery?**_____
19. **Have you had any DIFFICULT extractions in the past?**_____
20. **Have you lost any teeth?**_____
21. **Have they ever been replaced by: PLEASE CIRCLE Fixed Bridge, Removable Partial Denture or Implant**
22. **Do you have any other disease, condition or problem not listed above that you think I should know about?**

_____

_____

DATE_____ **SIGNATURE** _____