Patient Registration and Health Record

Date____________ Name_____________________________________ SSN_______________

Address____

Home #_________________ Work #___________________ Cell ________________________

Date of Birth________________Sex_______Employer_________________________________

Emergency Contact__________________________ Phone #_____________________________

⌈ Married, Spouse's Name: _______________________________⌈ Single ⌈ Other__________

Dental Insurance Carrier (if applicable)____

Medical Health

Name of Physician________________________ Date last seen by Physician______________

List medications and reason for taking (if you have a list with you, please allow us to make a copy)

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Please mark all that apply. Have you ever been treated for:

Heart Disease……………….___
High Blood Pressure……….___
Diabetes……………………___
Epilepsy/Seizures…………___
Congenital Heart Defects….___
Cancer……………………...___

Joint Replacement………___
Asthma…………………..___
Arthritis…………………___
Stroke…………………..___
AIDS/HIV…………...…___

Allergies to: Penicillin__ Codeine__ Local Anesthetics___ Other____________________

Women, are you pregnant____ If so, how far along________________________________

Dental Health

Reason for visit:____________________________________ Date of last dental visit_________

Have you had any problems with prior dental experiences?__ If so, please explain____________

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Do your gums bleed after brushing or flossing?______

Are you currently experiencing pain or sensitivity associated with your teeth?_______________

Do you have frequent headaches?___________ Do you clench or grind your teeth?__________

Please add anything else you feel is important for us to know:____________________________

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Thank you for giving us the opportunity to provide your dental care.