Patient Registration

Today's date: _____

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State _____ Zip:_____

Home#:_____Cell#:_____Work#:_____

Social Security:_____ Email:_____

If patient is a minor, who is legally responsible?:_____

Emergency contact:_____ Phone:_____ Relationship:_____

Pharmacy Name:_____ Pharmacy#: _____

Referring Dentist:_____

Insurance Information

Primary Insurance Company:_____ Phone#:_____

Group or Policy Number:_____ Subscriber ID#:_____

Subscriber's Name: _____SS #:_____ Birth Date: _____

Relationship to Patient:_____

Is patient covered by additional insurance? Yes No

Secondary Insurance Company:_____Phone#:_____

Group or Policy Number:_____ Subscriber ID#:_____

Subscriber's Name: _____SS #:_____Birth Date: _____

Relationship to Patient:_____

Health History

Are you presently under the care of a physician? Yes No

If yes, for what condition(s)?

Name of Physician: _____ Phone#: _____

In the last five years, have you ever been: (If yes, please explain)

Hospitalized? □ No □ Yes _____

Had a serious illness? □ No □ Yes _____

Had a major operation? □ No □ Yes _____

Have you ever had, or do you presently have any of the following conditions?

	Yes	No		Yes	No
Heart Surgery, Heart Disease, or Heart Attack	☐	☐	Thyroid Disease	☐	☐
Angina Pectoris/Chest Pain	☐	☐	Ulcer	☐	☐
High/Low Blood Pressure	☐	☐	AIDS or HIV positive	☐	☐
Heart Murmur	☐	☐	Hepatitis, Jaundice, or Liver Disease	☐	☐
Rheumatic Fever/Rheumatic Heart Disease	☐	☐	Blood Transfusion	☐	☐
Congenital Heart Lesions/Mitral Valve Prolapse	☐	☐	Drug Addiction/Alcoholism	☐	☐
Artificial Heart Valve	☐	☐	Hemophilia or Excessive Bleeding	☐	☐
Heart Pacemaker	☐	☐	Use of Fen-Phen, Redux, or Pondimin diet pills	☐	☐
Artificial Joint/Prosthesis	☐	☐	Use of Coumadin or other blood thinners	☐	☐
Stroke	☐	☐	Organ transplant	☐	☐
Kidney Disease	☐	☐	Psychiatric Treatment	☐	☐
Cancer or Tumors	☐	☐	Allergies/Hay Fever	☐	☐
Radiation Treatment of the Head or Neck	☐	☐	Asthma	☐	☐
Lung Disease/Tuberculosis	☐	☐	Sinus Trouble	☐	☐
Diabetes	☐	☐	Seizures/Epilepsy	☐	☐
Jaw Joint (TMJ) Problems	☐	☐	Arthritis	☐	☐
Dental Anxiety	☐	☐	Bisphosphonates/Osteoporosis drugs	☐	☐

Have you ever had an allergic or unusual reaction to any of the following?

	Yes	No		Yes	No
Local Anesthetics (“Novocaine”)	☐	☐	**Penicillin**	☐	☐
Aspirin or Ibuprofen (Advil)	☐	☐	**Erythromycin** or Other Antibiotics	☐	☐
Acetaminophen (Tylenol)	☐	☐	Sulfa Drugs	☐	☐
Barbiturates or Tranquilizers	☐	☐	Any Other Medication or Drugs	☐	☐
Codeine or Other Narcotics	☐	☐	Which Ones? _____		
Latex Materials	☐	☐	_____		

Women:

Are You Pregnant?	☐	☐	If Yes, How Many Months? _____
Are You Breast feeding?	☐	☐	
Are You Taking Birth Control Pills?	☐	☐	

If you are taking birth control pills, please read the following: Antibiotics may inactivate birth control medication. Therefore, if you are prescribed antibiotics during endodontic treatment, additional birth control methods should be used until your next menses.

Please list any medications (over the counter or prescription) that you are now taking:

_____

_____

_____

_____

If you have ever had any serious complications involving dental treatment, please explain:

_____

_____

_____

	Yes	No
I have received a copy of this office’s Notice of Privacy Practices	☐	☐

_____

Signature (Patient or Guardian) **Date**

Please state your Chief Complaint: _____

_____

Please indicate the answer (or answers) in each category that apply:

General

□ Pain today □ No pain today □ Pain in past □ No pain in past

When did pain first begin? _____

□ Pain begins spontaneously □ Pain only begins with stimulus □ Pain begins both spontaneously and with stimulus

Describe where you feel pain when it is present _____

_____

Duration of pain when present

□ Seconds □ Minutes □ Hours □ Continuous □ Off and on

Intensity of present pain

□ None □ Mild □ Moderate □ Severe

Intensity of past pain

□ None □ Mild □ Moderate □ Severe

Pain increased by

□ Heat □ Cold □ Pressure □ Biting □ Sweets □ Lying Down

□ Other _____

Pain decreased by

□ Heat □ Cold □ Pressure □ Medication (List) _____

□ Other _____

Character of pain

□ Dull □ Sharp □ Throb

□ Other _____

Swelling of the face or gums

□ None □ Today □ In past

Please describe when any swelling occurred and where it is/was located_____

_____

Has root canal treatment been started on any tooth? □ Yes □ No

If Yes, which tooth and when _____

Has root canal treatment been completed on any tooth in the area in question? □ Yes □ No

If Yes, which tooth and when _____

Have you had any recent dental work started or completed? □ Yes □ No

If Yes, please explain _____