PATIENT REGISTRATION

Mr.
Ms.
Mrs. ______________________________________ Age___ Birth Date ____________
Miss. *(Last)* *(First)* *(Middle)*

Social Security Number ______________________________ Driver's License Number ___________

Resident Address ______________________________ City ___________ Zip Code ______
Resident Phone Number (___) ____________________

Business/Employer's Name ______________________________ Occupation ____________
Business Address ______________________________ City ___________ Zip Code ______
Business Phone Number(___) ____________________
Emergency Contact Person's Name______________________ Relationship __________
Address ______________________________ City ___________
Phone Number (___) ____________________

Name of Physician ______________________________ City ___________
Physician's Phone Number (___) ____________________

In Case of Minor — Name of Parent/Guardian ______________________________
Person Responsible for Account ______________________________

Dental Insurance Name ______________________________
Referred by ______________________________

MEDICAL HISTORY

Height ______Weight ______ Sex ________
General Health: Excellent ____ Good ___ Fair ___ Poor ____
Date of last physical exam ______________________________

Circle any of the following which you have had or have at present:

Stroke	Ulcer	AIDS	Other Illnesses
Heart Attack or Disease	Asthma	Hepatitis	Urogenital
High Blood Pressure	Cancer or Tumor	Venereal Disease	Gastrointestinal
Angina Pectoris	Fainting or Dizziness	Drug or Alcohol Addiction	Respiratory
Rheumatic Fever	Epilepsy or Seizures	Any Transmissible Disease	Eye
Anemia	Psychiatric Illness		Ear
Hemophilia	Mental Disability		Nose
Diabetes	Physical Disability		Skin

Explain Circled ____

Have you had any hospitalization? Yes ___ No ___
Explain ____

Are you taking any medication now? Yes ___ No ___ What? ______________________

Are you allergic to Penicillin? ___ Local Anesthetic? ___ Other Medication? ______________
Are you pregnant? Yes ___ No ___

To the best of my knowledge, all of the proceeding answers are true and correct. Also, if I ever have any changes in information, said above, I will inform the doctor of dentistry at the next appointment.

Date __________ Signature ______________________________________

(Over)

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DENTAL HEALTH HISTORY

Reason for Visit ______________________________

When was your last dental visit? ______________

Have you ever had any serious reaction to previous dental treatment? ______________

Explain ______________________________

How often do your brush your teeth? ______________

How often do you floss? ______________

What type of toothbrush do you use? Soft ___ Medium ___ Hard ___ Nylon ___ Natural ___

Are your teeth sensitive to hot and cold, sweets, toothbrush contact, etc.? . . . Yes ___ No ___

Do your gums bleed while brushing? . . . . Yes ___ No ___

Do your gums feel tender or ever have bad smell in your mouth? . . . . Yes ___ No ___

Do you clench or grind your teeth while sleeping or during the day? . . . . . Yes ___ No ___

Do your jaws ever feel tired or have frequent headaches? . . . . Yes ___ No ___

Do you like the appearance of your teeth? . . . . Yes ___ No ___

Do you wear any prosthesis in your mouth (i.e., dentures, partials, etc.)? . . . . Yes ___ No ___

Do you gag easily? . . . . Yes ___ No ___

Do you smoke? . . . . Yes ___ No ___

Are you familiar with the term **preventive dentistry**? . . . . Yes ___ No ___

I hereby consent to treatment as necessary or desirable to care for the patient, including but not restricted to whatever drugs, X-rays, studies that maybe used by the attending doctor or his qualified designate.

Furthermore, I also acknowledge full responsibility for the payment in its entirety for all the services, which are rendered. Unless prior financial arrangements are made, a service charge of 1 1/2 % per month (18% per annum interest) may be charged on all accounts over 90 days old.

Date __________ Signature ______________________________

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Date	Tooth	Service	Charge	Paid	Balance