Date _____
M D Y

PATIENT REGISTRATION WELCOME TO OUR OFFICE *ALL INFORMATION IS CONFIDENTIAL.*

The following information is required by the dentist to assist in proper diagnosis and treatment.
Please feel free to ask receptionist for help in completing this form. PLEASE PRINT.

ADULT PATIENT or PARENT (Guardian) REGISTRATION ❒ Dr. ❒ Mr. ❒ Mrs. ❒ Ms ❒ Miss ❒ Other _____

Are you the: ❒ PATIENT ❒ PARENT (Guardian)

Name: _____
(last) (first) (initial)

Address: _____
(street) (city) (prov./state) (postal/zip code)

Date of Birth: _____ Age: ____ Sex: ____ Marital Status ____ Home Phone:( ) _____
M D Y

Driver's Lic. No.: _____ PHN(medical card #): _____

Employer: _____ Phone:( ) _____ Ext. _____

Email: _____

Family Physician _____ Phone:( ) _____

Medical Specialist _____ Phone:( ) _____

CHILD REGISTRATION or ADULT UNDER GUARDIANSHIP

Name: _____
(last) (first) (initial)

Prefers to be called (if different than above) : _____

Address: _____
(if different than above) (street) (city) (prov./state) (postal/zip code)

Date of Birth: _____ Age: _____ Sex: _____ Home Phone:( ) _____
M D Y

School: _____ Grade: _____

Person responsible for account: ❒ Self ❒ Spouse ❒ Other If other, please complete the following:

Name: _____ Home Phone:( ) _____

Address: _____
(street) (city) (prov./state) (postal/zip code)

Employer: _____ Phone:( ) _____ Ext. _____

Spouse's name: _____ Occupation: _____

Employer: _____ Phone:( ) _____ Ext. _____

In case of emergency, please notify: _____

Relationship: _____ Phone:( ) _____

Closest family relative: _____ Phone:( ) _____

Is another member of your family or relative a patient at our office? _____

Whom may we thank for referring you? _____

Do you have dental insurance? ❒ Yes ❒ No

PRIMARY DENTAL INSURANCE				SECONDARY DENTAL INSURANCE			
NAME OF INSURED		DATE OF BIRTH M /D /Y		NAME OF INSURED		DATE OF BIRTH M /D /Y	
EMPLOYER				EMPLOYER			
INSURANCE CARRIER				INSURANCE CARRIER			
GROUP/POLICY NUMBER		DIVISION		GROUP/POLICY NUMBER		DIVISION	
I.D. NUMBER OR S.I.N.	CERTIFICATE NUMBER		DEP. NO.	I.D. NUMBER OR S.I.N.	CERTIFICATE NUMBER		DEP. NO.
COVERAGE PERCENTAGE A B C D				COVERAGE PERCENTAGE A B C D			
LIMITS BASIC MAJOR ORTHO				LIMITS BASIC MAJOR ORTHO			
DEDUCTIBLE BASIC MAJOR		❒ PER PERSON ❒ PER FAMILY		DEDUCTIBLE BASIC MAJOR		❒ PER PERSON ❒ PER FAMILY	
SIGNATURE(S) REQUIRED: ❒ PATIENT ❒ INSURED ❒ EMPLOYER SUBMISSION: ❒ CARRIER ❒ PATIENT ❒ EMPLOYER ❒ OTHER				SIGNATURE(S) REQUIRED: ❒ PATIENT ❒ INSURED ❒ EMPLOYER SUBMISSION: ❒ CARRIER ❒ PATIENT ❒ EMPLOYER ❒ OTHER			

PATIENT'S NAME: _____

MEDICAL HISTORY

		YES	NO
1.	Do you have any serious illnesses or are you under the care of a physician?	☐	☐
2.	Do you use any prescription medications now? Please list: _____ _____	☐	☐
3.	Have you ever had any of the following: (*please circle*) jaundice, diabetes, high blood pressure, tuberculosis, asthma or lung disease, heart attack, stroke, heart murmur, heart disease, epilepsy, cancer, thyroid disease, kidney disease, mental or nervous conditions, arthritis, rheumatic fever, stomach problems, hives or skin rash, severe headaches. Please explain history briefly: _____ _____ _____	☐	☐
4.	Have you ever tested positive for hepatitis or HIV?	☐	☐
5.	Have you ever experienced any allergic reactions to any medications, latex rubber or other materials?	☐	☐
6.	Do you bruise easily, bleed abnormally, or have any blood disorders?	☐	☐
7.	Have you ever had any injury, surgery or radiation therapy to your face or jaws?	☐	☐
8.	Do you have any prosthetic implants, artificial heart valves, or artificial joints?	☐	☐
9.	Have you ever been required to take antibiotics prior to routine dental procedures such as cleaning?	☐	☐
10.	WOMEN ONLY – Are you pregnant? Which month? _____	☐	☐
11.	Do you have any disease, problem, or condition not listed above that you think the dentist should know about?	☐	☐

DENTAL HISTORY

		YES	NO
1.	When was your last dental visit? _____		
2.	Do you have any oral habits such as clenching, grinding your teeth, nail biting, or TMJ problems?	☐	☐
3.	What concerns you most about your dental health? _____ _____ _____		

Date: _____ **Signature:** _____