COME ORTHODONTICS & PEDIATRIC DENTISTRY

DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Last name	First name	Middle initial
Preferred Name	Date	
Address		
City	State	Zip
Date of Birth	SS#	
Home Phone	Work Phone	
Cell Phone	E-mail	
How would you prefer to be contacted? ❑Cell ❑Home ❑ Work ❑E-Mail		
❑Married ❑ Single ❑Widowed ❑Divorced ❑ Separated ❑Minor	Gender ❑ M ❑ F	
Occupation	Employer/School	Employer Phone
Whom may we thank for referring you?		
In the event of emergency, who should be notified?	Phone	

DENTAL INSURANCE

Name of insured			
Relationship to patient: ❑Self ❑Spouse ❑Child ❑Other_____________	Is insured a patient? ❑Yes ❑No		
Insured's SS#	Employer	Business Phone	Date of Birth
Employer Address	Insurance Company		
Insurance Address	Group #	Subscriber #	
Is patient covered by additional insurance? ❑Yes ❑No			
Name of insured			
Relationship to patient: ❑Self ❑Spouse ❑Child ❑Other_____________	Is insured a patient? ❑Yes ❑No		
Insured's SS#	Employer	Business Phone	Date of Birth
Employer Address	Insurance Company		
Insurance Address	Group #	Subscriber #	

DENTAL HISTORY

PATIENT'S NAME:	Reason for today's visit
Previous Dentist	Reason for changing dentists
Date of last dental visit	Date of last dental X-rays/cleaning
How often do you brush?	How often do you floss?

Is there anything that you would like to improve about your smile?

Place a mark next to "yes" or "no" to indicate if you have had any of the following

❑Yes ❑No	Bad breath	❑Yes ❑No	Facial or jaw injury	❑Yes ❑No	Mouth pain
❑Yes ❑No	Bleeding gums	❑Yes ❑No	Fingernail or foreign object biting	❑Yes ❑No	Orthodontic treatment
❑Yes ❑No	Gums swollen or tender	❑Yes ❑No	Cigarette, pipe, or cigar smoking	❑Yes ❑No	Pain around ear
❑Yes ❑No	Chew on one side of mouth	❑Yes ❑No	Grinding or clenching teeth	❑Yes ❑No	Periodontal treatment
❑Yes ❑No	Clicking or popping jaw	❑Yes ❑No	Blisters on lips or mouth	❑Yes ❑No	Sensitivity to cold
❑Yes ❑No	Pain in jaw	❑Yes ❑No	Loose teeth	❑Yes ❑No	Sensitivity to heat
❑Yes ❑No	Dry mouth	❑Yes ❑No	Broken fillings	❑Yes ❑No	Sensitivity to sweets
❑Yes ❑No	Sores or growths in mouth	❑Yes ❑No	Chewing tobacco	❑Yes ❑No	Sensitivity when biting

HEALTH HISTORY

Physician's name	Phone	Pharmacy	Phone

Have you ever been told that you need to take an antibiotic prior to dental treatment? ❑Yes ❑No For what condition?

Place a mark on "yes" or "no" to indicate if you have or had any of the following

❑Yes ❑No	AIDS/HIV	❑Yes ❑No	Circulatory Problems	❑Yes ❑No	Heart Murmur
❑Yes ❑No	Anemia	❑Yes ❑No	Congenital Heart Lesions	❑Yes ❑No	Heart Problems
❑Yes ❑No	Arthritis, Rheumatism	❑Yes ❑No	Cortisone/Steroid Treatments	❑Yes ❑No	Hepatitis Type ____
❑Yes ❑No	Artificial Heart Valves	❑Yes ❑No	Cough, persistent or bloody	❑Yes ❑No	Herpes
❑Yes ❑No	Artificial Joints	❑Yes ❑No	Diabetes	❑Yes ❑No	High Blood Pressure
❑Yes ❑No	Asthma	❑Yes ❑No	Emphysema	❑Yes ❑No	Kidney Disease
❑Yes ❑No	Bleeding abnormally	❑Yes ❑No	Epilepsy/Seizures	❑Yes ❑No	Liver Disease
❑Yes ❑No	Blood Disease	❑Yes ❑No	Fainting/Dizziness	❑Yes ❑No	Jaundice
❑Yes ❑No	Cancer/Chemotherapy	❑Yes ❑No	Glaucoma	❑Yes ❑No	Low Blood Pressure
❑Yes ❑No	Chemical dependency/Drug use	❑Yes ❑No	Headaches	❑Yes ❑No	Pacemaker
❑Yes ❑No	Nervous Problems	❑Yes ❑No	Mitral Valve Prolapse	❑Yes ❑No	Stomach Problems
❑Yes ❑No	Psychiatric Care	❑Yes ❑No	Radiation Treatment	❑Yes ❑No	Respiratory Disease
❑Yes ❑No	Taken Fen-Phen or Redux	❑Yes ❑No	Rheumatic Fever	❑Yes ❑No	Shortness of Breath
❑Yes ❑No	Sinus Trouble	❑Yes ❑No	Skin Condition	❑Yes ❑No	Stroke
❑Yes ❑No	Swollen Feet or Ankles	❑Yes ❑No	Thyroid Problems	❑Yes ❑No	Tuberculosis
❑Yes ❑No	Ulcers	❑Yes ❑No	Venereal Disease	❑Yes ❑No	Wear contact lenses
❑Yes ❑No	Infective Endocarditis	❑Yes ❑No	Organ Transplant	❑Yes ❑No	Surgery/Operation

Women: Are you pregnant? ❑Yes ❑No Due Date ______________ Are you nursing? ❑Yes ❑No Taking Birth Control? ❑Yes ❑No

Do you have any other health conditions that we should know about?

Have you been hospitalized or admitted to the hospital for emergency treatment during the past 2 years?

Please list all medications you are currently taking, including over the counter medications (use an additional paper if necessary)

Medicine____________________ Condition____________________ Medicine ____________________ Condition ____________________

Medicine____________________ Condition____________________ Medicine ____________________ Condition ____________________

Allergies: ❑ Aspirin ❑Ibuprofen ❑ Codeine ❑ Local Anesthetic ❑Aspirin ❑Latex ❑ Penicillin ❑ Sulfa ❑ Sulfites ❑ Other ______________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at my next appointment without fail.

Signature of Patient, Parent or Guardian____Date_______________Relation ____________________

Print Patient Name ____ Print Name of Signer if other than Patient ______________________________