ADULT REGISTRATION FORM

Patient Name_______________________________________ Home Phone _______________Cell Phone_______________
Address____ City __________________State_________ Zip_____________
Date of Birth_________________ Social Security # __________________ Email ____
In order to contact me I prefer you contact me by ☐ Home Phone ☐ Cell Phone ☐ Business Phone
If necessary, you may also contact me by ☐ Text ☐ Email

Employed by__________________________________Address _______________________________________Zip________
Present Position _______________________How long held__________________Business Phone _____________________

Spouse's Name__________________________________Date of Birth______________Social Security #_________________
Employed by ___________________________ Employer Address ____

Dental Insurance Co ________________________ Subscriber Name _____________________ Group#_________________
Address____ City________________________________Zip_______________
Who is financially responsible for this account? ☐ I am ☐ other party: ____

Whom may we thank for referring you? ____
Purpose of call: ☐ Regular Checkup ☐ Specific Problem:
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DENTAL INFORMATION

Date of last dental exam _______________________ Date of last complete set of x-rays (18) ___________
Name of previous Dentist ___________________________________ City or Town _____________________
Reason for leaving____

Please mark an (x) to any of the following that apply:

- ☐ Do your gums bleed when you brush your teeth?
- ☐ Are your teeth sensitive to cold, heat, sweets, or pressure?
- ☐ Is your mouth dry?
- ☐ Have you had Periodontal Surgery? When and by whom? ____
- ☐ Have you had any problem associated with past dental treatment? describe:_________________________________
- ☐ Are you currently experiencing dental pain or discomfort? Where?____
- ☐ Do you get/have earaches or neck pain?
- ☐ Do you brux or grind your teeth? ☐ Wear or have used a night guard or bruxism appliance?
- ☐ Do you get sores or ulcers in your mouth?
- ☐ Did you ever have a removable partial or full denture that you no longer wear?
- ☐ Have you ever had a serious injury to your head or mouth? Describe: ____
- ☐ Do you suffer from bad breath- Halitosis? ☐ Do you suck on mints, Tic Tacs, or sucking candies daily?
- ☐ Do you ever experience a burning tongue?
- ☐ Does your jaw ever lock open or closed, or do you experience clicks, noises, or pain when you chew? ____________
- ☐ Have you had complications from previous extractions?
- ☐ Have you ever been treated for TMJ? When and what was done? : ____
- ☐ Do you smoke cigarettes, a pipe, cigar or vape? For how long and how often? : _______________________________
- ☐ Have you had orthodontic treatment?
- ☐ Are you unhappy with your smile or bite? describe: ____
- ☐ Are you aware of any lumps or swelling in your mouth?
- ☐ Do you have any areas in your mouth where food constantly gets caught?
- ☐ What is one thing would you love to do to improve your smile or teeth? :

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MEDICAL INFORMATION

Primary Care Physician's Name____
Physician's Address ____City___________ Telephone_ _______________
Date of last exam_____________________ Last blood pressure _______________ Last A1C _______________________

List other doctors and reason: _________________________________ City___________ Telephone _ _______________
____ City___________ Telephone _ _______________
Have you had a serious illness, operation, or been hospitalized in the past five years? Please describe:
____

Please mark an (x) to any of the following that apply:

- ☐ Allergies to Penicillin or other antibiotics? list: ____
- ☐ Allergies to aspirin, local anesthetics, codeine, or any other medications? list: _________________________________
- ☐ Latex Allergy
- ☐ Heart/Cardiovascular disease ☐ Heart attack? when: _______________________________________
- ☐ Mitral Valve Prolapse ☐ Congenital heart defects
- ☐ Angina ☐ Pacemaker ☐ Defibrillator ☐ Heart Valve ☐ Stents ☐ Heart Murmur ☐ High BP:
- ☐ Stroke
- ☐ Diabetes ☐ Diet controlled ☐ Oral medication ☐ Insulin
- ☐ Cancer: ☐ Received chemotherapy ☐ Radiation ☐ Hormone Therapy
- ☐ Kidney problems
- ☐ Thyroid
- ☐ Liver ☐ Hepatitis A, B, C, D? (Please circle)
- ☐ Tuberculosis
- ☐ Sinus problems ☐ Seasonal allergies
- ☐ Hemophilia, Anemia or blood problems:
- ☐ Rheumatic Fever or Scarlet Fever
- ☐ Artificial joints or prosthesis? Describe and list dates: ____
- ☐ Sleep disorders/ sleep apnea ☐ CPAP ☐ Snoring
- ☐ Asthma ☐ Have/ use Inhaler? How often? : ____________________ ☐ COPD ☐ Emphysema
- ☐ Mental health disorders ☐ Depression ☐ Panic attacks ☐ Other :_________________________________
- ☐ Epilepsy, fainting spells or seizures ☐ Neurological disorders
- ☐ Gastrointestinal disease: ☐ Ulcers ☐ Acid Reflux ☐ Eating disorders
- ☐ Excessive bleeding from cuts or extractions ☐ Take blood thinners
- ☐ Rheumatoid Arthritis ☐ Osteoarthritis
- ☐ Autoimmune Disease
- ☐ Osteoporosis ☐ Osteopenia ☐ Receive Prolia injection ☐ Take other medication: __________________
- ☐ AIDS or HIV infection
- ☐ Wear a hearing aid
- ☐ Currently pregnant? If so, due date: _______________
- ☐ Any medical issues or treatment that is not listed above: ____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

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____
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Patient Signature________________________________**Date**_________________________
Reviewed by __________________