REGISTRATION

Name ______________________ Date ______________

Male ☐ Female ☐ Social Security Number ______________ Name of Spouse ______________

Referred by: ☐ Yellow Pages ☐ Newspaper ☐ Friend ☐ Other ______________

Address ______________ City ______________ State ______ Zip ______

Age ______ Birthdate ______________ Home Phone ______________

Email Address ______________ Cell Phone Number ______________

Employer (self) ______________ Employer (spouse) ______________

Business Phone ______________ Business Phone ______________

IF MINOR

Father's Name ______________ Mother's Name ______________

Father's Social Security Number ______________ Mother's Social Security Number ______________

Father's Employer ______________ Mother's Employer ______________

Father's Date of Birth ______________ Mother's Date of Birth ______________

Father's Business Phone ______________ Mother's Business Phone ______________

PERSON RESPONSIBLE FOR ACCOUNT ______________

All professional services rendered are charged to the patient. All necessary forms will be completed to expedite insurance carrier payment. The patient is responsible for all fees regardless of insurance coverage. **IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.**

SIGNATURE ______________

DENTAL HEALTH QUESTIONNAIRE

INSTRUCTIONS: Please answer the following questions by circling, and if applicable, by entering the appropriate response.

Previous Dentist ______________ Date of Last Visit ______________

Are you presently ill or under the care of a physician? .... Yes ☐ No ☐

If yes, please describe: ______________

History of hospitalizations: ______________

Any allergies? Yes ☐ No ☐ If yes, please list: ______________

Medications presently taking (including aspirin, etc.): ______________

Do you use tobacco products? Yes ☐ No ☐ If yes, what type: ______________

Any family history of (please circle): Heart Disease Cancer Diabetes Seizures

HAVE YOU EVER HAD OR HAVE YOU NOW: (Please check at the RIGHT of each item.)

(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW
Epilepsy or Seizures				Hemophilia				Ulcers			
Fainting or Dizziness				Bruise or bleed easily				Kidney problems			
Nervousness				Heart problems or Angina				Venereal disease			
Stroke				Hypertension				Diabetes			
Glaucoma				Rheumatic fever				Thyroid disease			
Cold sores (Herpes)				Heart murmur				AIDS/HTLV-III positive			
Persistent cough				Mitral valve prolapse				Arthritis			
Emphysema				Congenital heart lesions				Painful joints (incl. jaw)			
Tuberculosis/PPD positive				Heart surgery				Prosthetic joint(s)			
Asthma				Prosthetic heart valve(s)				Hives			
Hay fever				Pacemaker				Steroid medication(s)			
Sinus problems				Blood tranfusion(s)				Drug addiction			
Anemia				Liver disease				Alcoholism			
Sickle cell disease				Yellow jaundice				Unexplained weight change			
G-6PD deficiency				Hepatitis — type:				Cancer/radiation therapy			

	YES	NO	DON'T KNOW
1. HAVE YOU EVER BEEN TOLD THAT YOU SHOULD NOT DONATE BLOOD?			
2. FEMALES: Are you taking birth control pills (BCPs)?			
Are you or might you be pregnant? (Estimated delivery: ______________)			
3. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE? If yes, please describe: ______________			

PHYSICIAN: Name ______________ Phone ______________

Address ______________

I HAVE ANSWERED THE ABOVE QUESTIONS TO THE BEST OF MY KNOWLEDGE. Signature ______________