BROWN FAMILY DENTISTRY

PATIENT REGISTRATION

Patient's Name | Birth Date | Age | Sex: M F

Home Address | City | State | Zip

Home Phone #

Work Phone #

YOUR Cell Phone #

YOUR E-mail Address | YOUR Soc Sec #

YOUR Driver's License Number (is not necessary if you are paying at the time of service)

Your Place of Employment: | Your Occupation

Please Circle One: Single Married Separated Widow

If Patient is a minor we need:

Mother's Name & Birth Date

Father's Name & Birth Date

Person Paying this bill:

Name of spouse (or parent if minor):

Spouse's (or Parent's) employer | Spouse's Soc Sec. # | Work Phone #

EMERGENCY INFORMATION

Name, Address & Telephone Number of a relative not living with you:

Family Physician: | **Phone Number:**

How did you hear about our office?

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name | DOB | SS#

Insured's Employer

Insurance Co

Insurance Co Address

Phone #

Group # | Policy #

If you have dual insurance coverage, complete this for the second coverage (this office bills primary insurance only)

Insured's Name | DOB | SS#

Insured's Employer

Insurance Co

Insurance Co Address

Phone #

Group # | Local #

Patient Signature (or Parent of Child) | **Date** | **Dentist's Signature**

DENTAL HISTORY

Please check the following:	YES	NO
-Sensitivity (hot, cold, sweet) Where? UR LR UL L		
-Headaches, ear aches, neck aches or jaw joint pain	☐	☐
-Mouth ulcers or cold sores	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath	☐	☐
-Snoring	☐	☐

Do you have or have you had any of the following?

-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Gum treatments	☐	☐

Please share the following dates

-Your last cleaning ___/___
-Your last oral canser screening ___/___
-Your last complete X-Rays ___/___

Name of Previous Dentist_____

City_____ State_____

Phone Number _____

What is the most important thing to you about your future smile and dental health?

_____

	YES	NO
If you could whiten your teeth for a cost anyone could afford, whould you do it?	☐	☐
Do you smoke or use chewing tobacco? How much? For how long?	☐	☐

If I could change my smile, I would:

-Make my teeth whiter	☐	☐
-Make my teeth straighter	☐	☐
-Close spaces	☐	☐
-Replace metal fillings with tooth colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Repair chipped teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Have a smile makeover	☐	☐

On a scale of 1–10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____

What is the most important thing to you about your dental visit today?

_____

MEDICAL HISTORY

Y N	Y N	Y N	Y N
☐ ☐ Allergies (Seasonal)	☐ ☐ Excessive Bleeding	☐ ☐ Nervousness/Depression	☐ ☐ Ulcers
☐ ☐ Anemia	☐ ☐ Glaucoma	☐ ☐ Pacemaker	☐ ☐ OTHER (please list):
☐ ☐ Artificial Heart Valve	☐ ☐ Heart Conditions	☐ ☐ Phen Fen (1 month +)	_____
☐ ☐ Artificial Joints	☐ ☐ Heart Murmur	☐ ☐ Radiation (head/neck)	_____
☐ ☐ Asthma	☐ ☐ Hepatitis A	☐ ☐ Respiratory Problems	_____
☐ ☐ Blood Disease	☐ ☐ Hepatitis B	☐ ☐ Rheumatic Fever	_____
☐ ☐ Bruise Easily	☐ ☐ Hepatitis C	☐ ☐ Rheumatism	_____
☐ ☐ Cancer	☐ ☐ High Blood Pressure	☐ ☐ Scarlet Fever	_____
☐ ☐ Chemotherapy	☐ ☐ HIV/AIDS	☐ ☐ Seizures	For WOMEN Only
☐ ☐ Diabetes	☐ ☐ Jaundice	☐ ☐ Stomach Problems	☐ Birth Control Pills
☐ ☐ Dizziness/Fainting	☐ ☐ Kidney Disease	☐ ☐ Stroke	☐ Breast-feeding
☐ ☐ Drug Addiction	☐ ☐ Liver Disease	☐ ☐ Thyroid Disease	☐ Pregnant
☐ ☐ Emphysema	☐ ☐ Mitral Valve Prolapse	☐ ☐ Tuberculosis	1-3 mos 3-6 mos 6-9mos

Do you have an allergy to any of the following?

☐ ☐ Aspirin	☐ ☐ Nitrous Oxide
☐ ☐ Erythromycin	☐ ☐ Codeine☐
☐ ☐ Latex	☐ ☐ Penicillin
☐ ☐ Local Anesthetic	☐ ☐ Other:

Are you under a physician's care? For what?

_____

What medications are you currently taking?

_____

_____

Is there any other Medical or Dental Information We Should Know About? _____

_____