SMITH
FAMILY DENTISTRY

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Patient Registration Form

Patient Information-

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____

Sex: ○ Male ○ Female Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Social Security Number: _____

Employment Status: ○ Full Time ○ Part Time ○ Retired ○ Other Student Status: ○ Full Time ○ Part Time

Referred by: _____

Emergency Contact-

Name: _____ Phone Number: _____

Responsible Party (if someone other than the patient)-

First Name: _____ Last Name: _____ Middle Initial: _____

Mailing Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: ○ Male ○ Female Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Social Security Number: _____

Primary Insurance Information-

Name of Insured: _____ Social Security Number: _____ Date of Birth: _____

Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Member ID: _____ Group #: _____

Secondary Insurance Information-

Name of Insured: _____ Social Security Number: _____ Date of Birth: _____

Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Member ID: _____ Group #: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Allergies: Are you allergic to or have you had a reaction to any of the following:

○ Aspirin	○ Penicillin	○ Codeine	○ Latex	○ Sulfa Drugs
○ Local Anesthetics	○ Acrylic	○ Metal		

○ Other (please list) _____

Are you taking any medications, pills, or drugs?	○ Yes	○ No	If yes, please list _____
Are you under a physician's care now?	○ Yes	○ No	If yes, why _____
Have you had any surgeries?	○ Yes	○ No	If yes, what _____
Do you use tobacco?	○ Yes	○ No	
Do you use controlled substances?	○ Yes	○ No	

Women: Are you……

○ Pregnant ○ Nursing ○ Taking birth control

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

Artificial Heart Valve	○ Yes	○ No	Cortisone Medicine	○ Yes	○ No	Shingles	○ Yes	○ No
Artificial Joint	○ Yes	○ No	Diabetes	○ Yes	○ No	Sickle Cell Disease	○ Yes	○ No
Heart Attack/Failure	○ Yes	○ No	Herpes	○ Yes	○ No	Sinus Trouble	○ Yes	○ No
When? _____			High Blood Pressure	○ Yes	○ No	Blood Transfusion	○ Yes	○ No
Mitral Valve Prolapse	○ Yes	○ No	High Cholesterol	○ Yes	○ No	When? _____		
Convulsions	○ Yes	○ No	Hives/Rash	○ Yes	○ No	Frequent Headaches	○ Yes	○ No
Epilepsy/Seizures	○ Yes	○ No	Hypoglycemia	○ Yes	○ No	Genital Herpes	○ Yes	○ No
AIDS/HIV Positive	○ Yes	○ No	Irregular Heartbeat	○ Yes	○ No	Lung Disease	○ Yes	○ No
Alzheimer's Disease	○ Yes	○ No	Kidney Problems	○ Yes	○ No	Tuberculosis	○ Yes	○ No
Anaphylaxis	○ Yes	○ No	Breathing Problems	○ Yes	○ No	Congenital Heart Disorder	○ Yes	○ No
Anemia	○ Yes	○ No	Asthma	○ Yes	○ No	Heart Trouble/Disease	○ Yes	○ No
Emphysema	○ Yes	○ No	Bruise Easily	○ Yes	○ No	Radiation Treatment	○ Yes	○ No
Excessive Bleeding	○ Yes	○ No	Glaucoma	○ Yes	○ No	Recent Weight Loss	○ Yes	○ No
Excessive Thirst	○ Yes	○ No	Hay Fever	○ Yes	○ No	Renal Dialysis	○ Yes	○ No
Fainting Spells	○ Yes	○ No	Osteoporosis	○ Yes	○ No	Angina	○ Yes	○ No
Dizziness	○ Yes	○ No	Tumors/Growths	○ Yes	○ No	Arthritis/Gout	○ Yes	○ No
Frequent Cough	○ Yes	○ No	Yellow Jaundice	○ Yes	○ No	Blood Disease	○ Yes	○ No
Stomach Problems	○ Yes	○ No	Hemophilia	○ Yes	○ No	Leukemia	○ Yes	○ No
Intestine Disease	○ Yes	○ No	Hepatitis A	○ Yes	○ No	Liver Disease	○ Yes	○ No
Stroke	○ Yes	○ No	Hepatitis B or C	○ Yes	○ No	Low Blood Pressure	○ Yes	○ No
Cancer	○ Yes	○ No	Rheumatic Fever	○ Yes	○ No	Thyroid Disease	○ Yes	○ No
Chemotherapy	○ Yes	○ No	Rheumatism	○ Yes	○ No	Chest Pains	○ Yes	○ No
Heart Murmur	○ Yes	○ No	Scarlet Fever	○ Yes	○ No	Cold Sores/Blisters	○ Yes	○ No
Ulcers	○ Yes	○ No	Blood Thinner	○ Yes	○ No	Heart Pacemaker	○ Yes	○ No
Psychiatric Care	○ Yes	○ No						

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ○ Yes ○ No

Name of physician or dentist making recommendation? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form and/or providing updated health information.

Signature of Patient, Parent or Guardian: _____ Date: _____

Smile Analysis

1. Do you love the way your smile looks? □ Yes □ No

2. Do you feel comfortable showing your teeth when you laugh or smile? □ Yes □ No

3. If you could change anything about your smile, what would it be? (check all that apply)
   □ Color of your teeth □ Gaps between your teeth □ Alignment of your teeth
   □ Size/Shape of your teeth □ Other _____

4. Do you or someone in your family have issues with any of the following? (check all that apply)
   □ Chronic Bad Breath □ Grinding Teeth □ Snoring
   □ Periodontal (gum) disease □ Other _____