CHOICE DENTAL
family dentistry

PATIENT REGISTRATION

Patient Basic Information

First Name:	Last Name:	Middle Initial:
Preferred Name:		
Person who is completing the form for the patient is : □ *Patient/Policy Holder*		□ *Guardian/Parent/Spouse*

Patient Information (section1):

Address:		
City, State, Zip:		
Home Phone:	Work Phone:	Cell Phone:
Sex:	Marital Status*:*	
Birth date:	Social Security #:	Driver's License #:
E-mail:		□ *check if you prefer email over phone reminder*

Patient Information (section 2):

Occupation:	Patient's Employer:
Business Address:	
Student Status: ○*Full Time* ○ *Part Time*	Name of School/College:
Person to Contact in Case of Emergency:	Phone:
Whom May We Thank for Referring You?	

Spouse or Parent/Guardian's information:

First Name:	Last Name:	Middle Initial:
Address:		
City, State, Zip:		
Home Phone:	Work Phone:	Cell Phone:
Birth date:	Social Security #:	Driver's License #:
Relationship to Patient:	Spouse/Parent's Employer:	

Primary Insurance Information:

Name of Insured:	Relationship to Insured: ○*Self* ○*Spouse* ○*Child* ○ *Other*
Employer ID:	Carrier ID:
Insured Social Security #:	Insured Birth date:
Employer:	Insurance Company:
Address:	Address:
Address 2:	Address 2:
City, State, Zip:	City, State, Zip:

Secondary Insurance Information:

Name of Insured:	Relationship to Insured*:* ○*Self* ○*Spouse* ○*Child* ○ *Other*
Employer ID:	Carrier ID:
Insured Social Security #:	Insured Birth date:
Employer:	Insurance Company:
Address:	Address:
Address 2:	Address 2:
City, State, Zip:	City, State, Zip:

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MEDICAL HISTORY

Patient Name_____ Birth Date _____

Name of Physician and Location_____ Office Phone_____

1.	Are you under a physician's care now?	Yes	No	10.	Are you allergic to any of the following?		
2.	Have you ever been hospitalized or had a major operation? If yes, please explain_____ _____	Yes	No		Local Anesthetics	Yes	No
					Penicillin or any other Antibiotics	Yes	No
					Sulfa Drugs	Yes	No
3.	Have you ever had a serious head or neck injury?	Yes	No		Barbiturates	Yes	No
4.	Are you taking any medications, pills, or drugs? If yes, what medications are you taking? _____ _____	Yes	No		Sedatvies	Yes	No
					Iodione	Yes	No
					Aspirin	Yes	No
5.	Have you ever taken Fen-Phen or Redux?	Yes	No		Any Metal(e.g.nickel, mercury, etc)	Yes	No
6.	Have you ever taken Fosamax, Boniva, Actonel or any cancer medication containing bisphosphonates?	Yes	No		Latex Rubber	Yes	No
					Other_____		
7.	Do you use tobacco	Yes	No	11.	Women Only		
8.	Do you use controlled substances?	Yes	No		Are you pregnant or think you may be pregnant?	Yes	No
9.	Do you need to pre-medicate? If yes, please explain _____	Yes	No		Are you nursing?	Yes	No
					Are you taking oral contraceptives?	Yes	No

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

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

_____

DENTAL HISTORY

Name of Previous Dentist and Location_____ Date of Last Exam_____

1.	Do your gum bleed while brushing or flossing?	Yes	No	8.	Do you have frequent headaches?	Yes	No
2.	Are your teeth sensitive to hot or cold liquids/ foods?	Yes	No	9.	Do you clench or grind your teeth?	Yes	No
3.	Are your teeth sensitive to sweet or sour liquids/foods?	Yes	No	10.	Do you bite your lips or cheeks frequently?	Yes	No
				11.	Have you ever had any difficult extraction in the past?	Yes	No
4.	Do you feel pain to any of your teeth?	Yes	No				
5.	Do you have any sores or lumps in or near your mouth?	Yes	No	12.	Have you ever had any prolonged bleeding following extractions?	Yes	No
6.	Have you had any head, neck or jaw injuries?	Yes	No	13.	Have you had any orthodontic treatment?	Yes	No
7.	Have you ever experience any of the following problem in your jaw?			14.	Do you wear denture or partials? If yes, date of placements?	Yes	No
	○ Clicking	Yes	No	15.	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	Yes	No
	○ Pain (Joint, ear, side of face)	Yes	No				
	○ Difficulty in opening or closing	Yes	No	16.	Do you like your smile	Yes	No
	○ Difficulty in chewing	Yes	No				

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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MEDICAL HISTORY UPDATE

Patient Name____________________________________ Birthday ____/_____/______ Patient Number_______

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health and mediations have changed as follows (if no change, write "No Change") :

____

____

____
Signature of Patient (or Guardian) Date

Update reviewed by Dr.____

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health and mediations have changed as follows (if no change, write "No Change") :

____

____

____
Signature of Patient (or Guardian) Date

Update reviewed by Dr.____

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health and mediations have changed as follows (if no change, write "No Change") :

____

____

____
Signature of Patient (or Guardian) Date

Update reviewed by Dr.____

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health and mediations have changed as follows (if no change, write "No Change") :

____

____

____
Signature of Patient (or Guardian) Date

Update reviewed by Dr.____

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