Adult Registration & Health Questionnaire

Date:_____

Patients Name: First_____Middle_____Last_____Date of Birth:_____

Home Address: Street_____City_____State_____Zip_____

Home Phone:_____ Cell:_____Work:_____

Best phone number to reach you:_____E-mail:_____

Social Security #_____Driver's License #_____

What is your occupation?_____ Employer:_____

Do you have dental Insurance?_____ Insurance company name:_____

Name of policy holder: First_____Middle_____Last_____

Member ID # (Policy holder's ID #)_____Date of Birth of policy holder:_____

Where is policy holder employed?_____**Do you have any additional insurance Y/N**

Name and address of person responsible for payment:_____

_____

(If married) Spouse's name:First_____Middle_____Last_____

Occupation of spouse:_____Employer:_____

Spouse's work phone:_____ Spouse's cell phone:_____

How did you hear about our office?_____Who may we thank?_____

Dental History

Reason for today's visit:_____

Former Dentist:_____

Address:_____

Date of last dental care:_____Date of last full mouth x-rays:_____

What treatment was performed at last visit?_____

What concerns you most about your teeth?_____

Have you had any teeth extracted?_____Were you told why they should be replaced?_____

Are you interested in comprehensive dental care?_____

Do you have any cosmetic concerns?_____

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

☐ **Bad breath**	☐ **Grinding teeth**	☐ **Sensitivity to hot**
☐ **Bleeding gums**	☐ **Loose teeth or broken fillings**	☐ **Sensitivity to sweet**
☐ **Clicking or popping jaw**	☐ **Periodontal treatment**	☐ **Sensitivity when biting**
☐ **Food collection between your teeth**	☐ **Sensitivity to cold**	☐ **Sores or growths in your mouth**

How often do you floss?_____How often do you brush?_____Do you use an electric tooth brush? Y / N

Medical History

Patients Name: _____

Medical Doctors Name: _____ Date of Last Medical Visit: _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? _____ If yes, give approximate dates _____

Sex _____ (Women) Are you pregnant? **YES / NO** If yes, how many weeks? _____ Nursing? **YES/ NO**

Taking birth control pills? **YES/ NO**

Check (✓) yes or no if you have ever had any of the following:

Y	N		Y	N	
☐	☐	Abnormal bleeding	☐	☐	Heart Surgery
☐	☐	Alcohol Abuse	☐	☐	Heart Disease
☐	☐	Allergies	☐	☐	Hemophilia
☐	☐	Anemia	☐	☐	Hepatitis A
☐	☐	Angina Pectoris	☐	☐	Hepatitis B
☐	☐	Arthritis	☐	☐	Hepatitis C
☐	☐	Artificial Joints	☐	☐	High Blood Pressure
☐	☐	Artificial Heart Valve	☐	☐	HIV
☐	☐	Asthma	☐	☐	AIDS
☐	☐	Blood Transfusion	☐	☐	Kidney Problems
☐	☐	Cancer	☐	☐	Liver Disease
☐	☐	Chemotherapy	☐	☐	Low Blood Pressure
☐	☐	Radiation Treatment	☐	☐	Mitral Valve Prolapse
☐	☐	Colitis	☐	☐	Pace Maker
☐	☐	Congenital Heart Defect	☐	☐	Rheumatic Fever
☐	☐	Diabetes	☐	☐	Seizures
☐	☐	Difficulty Breathing	☐	☐	Shingles
☐	☐	Drug Abuse	☐	☐	Sickle Cell Disease
☐	☐	Emphysema	☐	☐	Sinus Problems
☐	☐	Epilepsy	☐	☐	Stroke
☐	☐	Fainting Spells	☐	☐	Thyroid Problems
☐	☐	Fever Blisters	☐	☐	Tuberculosis
☐	☐	Frequent Headaches	☐	☐	Ulcers
☐	☐	Glaucoma	☐	☐	Venereal Disease
☐	☐	Hay Fever	☐	☐	Yellow Jaundice
☐	☐	Heart Attack			

Allergies:

Y	N	
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Erythromycin
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Dental Anesthetics
☐	☐	Metals
☐	☐	Jewelry
☐	☐	Latex

Do you smoke or use tobacco? Yes / No

Medications Currently Taking (please list all):

_____

_____

_____

_____

_____

_____

_____

Other Allergies:_____

Please give our staff 2-business days notice of any change to your future appointments. Any appointment cancelled within 1 business day of the scheduled visit is considered a broken appointment and will be subject to a $75.00 fee.

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____**Date**_____