Patient Registration Form

Patient Information

Patient Name:______________________________________Nickname____________________
Street Address:____
City______________________________ State__________ Zip______________
Soc. Sec. #____________________Birth date________________Age_____________________
Home Phone___________________________Business Phone____________________________
Employed by ____
Employer's Address________________________________City______________Zip__________

Who can we thank for referring you to our practice?___________________________________

Person financially responsible for this account?_______________________________________

Spouse/Parent Information

Please provide parent/guardian information if patient is a minor.

Spouse/ Parent Name____
Spouse/ Parent Employed By____
Employer's Address____
City______________________________State_________________Zip ____________________
Business Phone____________________________

Emergency Information

Who should we contact in the event of an emergency?__________________________________
Emergency Phone Number____
Family Doctor's Name/ Address/ Phone ____

Dental Insurance Information

Complete any information that applies, do not include medical insurance.

Primary Carrier____
Who is the Insured Person?____
Insured's Soc. Sec. #________________________ Date of Birth__________________________
Carrier Address____________________________City_____________State_____Zip________
Phone #______________________________ID/Group #_____________________________

Secondary Carrier____
Who is the Insured Person?____
Insured's Soc. Sec. #________________________Date of Birth___________________________
Carrier Address____________________________City_____________State_____Zip________
Phone #______________________________ID/Group #_____________________________

Please Turn Over ...

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Medical/ Dental History

1. Are you having pain or discomfort at this time ?.. Yes No
2. Do you feel nervous about having dental treatment?.. Yes No
3. Have you ever had a bad experience in a dental office?.. Yes No
4. Have you been hospitalized during the past two years?... Yes No
5. Have you been under the care of a medical doctor during the past two years ? .... Yes No
6. Have you taken any prescription medicines or drugs during the past two years ? .... Yes No
7. Are you allergic to or made sick by penicillin, aspirin, codeine, or any other drug/ medication ? Yes No
8. Have you ever had a bleeding or clotting problem ?.. Yes No
9. Do you smoke or use smokeless tobacco products ?... Yes No
10. Name /address of previous dentist?..
11. When was your last dental visit? What was done?..

12. Please circle any of the following which you have had or have at present:

Heart Failure	Emphysema	HIV Positive or Aids	Bonding (to teeth)
Heart Disease or Attack	Persistent Cough	Hepatitis A (Infectious)	Eating Disorder (anorexia)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (Serum)	Root Canal Treatment
High Blood Pressure	Asthma	Liver Disease	Partial Dentures
Heart Murmur	Hay Fever	Yellow Jaundice	Full Dentures
Rheumatic Fever	Sinus Trouble	Blood Transfusion	Grind Teeth
Congenital Heart Lesions	Allergies or Hives	Drug Addiction Problem	Bad Breath
Scarlet Fever	Diabetes	Hemophilia	Bleeding Gums
Artificial Heart Valve	Thyroid Disease	Cold Sores	Difficulty Eating
Heart Surgery	Heart Pacemaker	Genital Herpes	Impacted Wisdom Teeth
Artificial Joint	Pain in Jaw Joints	Epilepsy or Seizures	Injuries to Mouth
Anemia	Bruise Easily	Fainting or Dizzy Spells	TMJ Problems (Jaw Joint)
Stroke	Rheumatism	Nervousness	Teeth Extracted
Kidney Trouble	Cortisone Medicine	Psychiatric Treatment	Adjustments to your bite
Ulcers	Glaucoma	Sickle Cell Disease	Orthodontic Treatment
Arthritis	Venereal Disease	Syphilis or Gonorrhea	Crowns (Caps), Bridges
Radiation or cobalt treatment	Cancer or Tumor	Chemotherapy (For -cancer, Leukemia, etc.)	Periodontal Treatment Reaction to local anesthesia

13. Do you have any disease, condition, or problem not listed above ? .... Yes No
14. Are you on any type of special diet ? .... Yes No
15. Are you happy with the way your teeth look ? .... Yes No
16. If not, what would you change? ....
17. Do your teeth collect food in any particular areas?...
18. Do you have any trouble eating ? ....
19. Are there any teeth or areas that are sensitive to hot, cold, or chewing?.......................................
20. How would you like your teeth to look in 10 years ?..
21. What medicines are you taking at this time?...

....

22. *WOMEN:* Are you pregnant now or do you anticipate becoming pregnant ?..Yes No
Are you taking oral contraceptives ? ....Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change I will inform the undersigned dentist at the next appointment without fail. I authorize Dr. Mark Pitel, his associates, and or assistants to examine diagnose and perform dental treatments on myself or the patient listed above (if a minor). I understand that I am responsible for all costs of dental treatment. I consent to any photography, filming, recording and x-ray procedures to be performed for teaching purposes or for the advancement of dentistry, provided that my identity is not revealed.

__________ ______________________________ _________________________

Date Signature of Patient, Parent or Guardian Signature of Dentist