Patient Registration Form

Patient Information

Patient Name:_____Nickname_____
Street Address:_____
City_____ State_____ Zip_____
Soc. Sec. #_____Birth date_____Age_____
Home Phone_____Business Phone_____
Mobile Phone_____ email address_____
Employed by _____Occupation_____
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/ Significant Other/ 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. #_____ Insured's Date of Birth_____
Carrier Address_____City_____State_____Zip_____
Phone #_____ID/Group #_____

Secondary Carrier_____
Who is the Insured Person?_____
Insured's Soc. Sec. #_____Insured's Date of Birth_____
Carrier Address_____City_____State_____Zip_____
Phone #_____ID/Group #_____

Please Turn Over ...

Patient 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.	Do you snore, have sleep apnea or use a CPAP machine?	Yes	No
11.	Name /address of previous dentist?.....		
12.	When was your last dental visit? What was done?.....		

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

Heart Failure	Emphysema	Hepatitis A (Infectious)	Bonding (to teeth)
Heart Disease or Attack	Persistent Cough	Hepatitis B (Serum)	Eating Disorder (anorexia)
Angina Pectoris	Tuberculosis (TB)	Hepatitis C	Root Canal Treatment
Heart Murmur	Asthma	Other Liver Disease	Partial Dentures
High Blood Pressure	Hay Fever	Yellow Jaundice	Full Dentures
Rheumatic Fever	Sinus Troubles	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
Gastric Ulcers	Glaucoma	Sickle Cell Disease	Orthodontic Treatment
Arthritis	Venereal Disease	Syphilis, Gonorrhea or HPV	Crowns (Caps), Bridges
Radiation or cobalt treatment	Cancer or Tumor	Chemotherapy (For -cancer,	Periodontal Treatment
Lyme Disease	HIV + or AIDS	Leukemia, etc.)	Reaction to local anesthesia

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

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

I certify that to the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes to my health, or if my medicines change I will inform the undersigned dentist at the next appointment without fail. I consent to and 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 fully responsible for the costs of my dental treatment. I further consent to allow photography, filming, and video recording procedures to be performed of my treatment, teeth and likeness for documentation, educational purposes or for the advancement of dentistry, provided that my identity is not revealed.

Date	Signature of Patient, Parent or Guardian	Signature of Dentist