SMILE DESIGN BY Sisler

1020 Orrstown Rd., Shippensburg, PA 17257

Dental Registration and History

PATIENT INFORMATION

Date: _____
Patient Name: _____
Nickname: _____
Patient Address: _____
_____
Patient Phone #: _____
Patient Social Security #: _____
(used for insurance purposes only)
Date of Birth: _____
Sex: _____ F _____ M
Marital Status: _____

ACCOUNT RESPONSIBILITY

Name: _____
Phone #: _____
Email Address: _____
Date of Birth: _____
Patient Social Security #: _____
(used for insurance purposes only)
Employer: _____
Employer Address: _____
_____
Employer Phone #: _____
SPOUSE'S NAME: _____
Date of Birth: _____
Patient Social Security #: _____
(used for insurance purposes only)
Employer: _____
Employer Address: _____
_____
Employer Phone #: _____

INSURANCE INFORMATION

Subscriber Name: _____
Subscriber Address: _____
_____
Subscriber ID #: _____
Group #: _____
Insurance Co. Name: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone #: _____

DENTAL HISTORY

Reason for today's visit: _____
_____
Former Dentist: _____
Date of last dental treatment: _____
Date of last dental X-Rays: _____

Do your gums bleed? Yes No

Have you ever had gum treatment? Yes No

How many times a day do you brush your teeth? _____

How many times a week do you floss? _____

Do you like your smile? Yes No
If no, what would you like to change? _____
_____
_____

Do you now or have you ever experienced pain/
discomfort in your jaw joint (TMJ)? Yes No

Are your teeth sensitive to heat or cold? Yes No

Have you lost any teeth? Yes No

Who may we thank for referring you? _____
_____

EMERGENCY CONTACT INFORMATION

Name: _____
Relationship: _____
Home Phone #: _____
Work Phone #: _____

Please complete back side of form

Health History

Physician's Name: _____ Physician's Phone #: _____

Has a physician informed you to take a premedication (Antibiotic) before dental treatment? Yes or No
Please circle reason(s): Artificial Joints Artificial Heart Valves Congenital Heart Defect

Have you ever had any of the following diseases or medical problems:

Y N Anemia
Y N Arthritis
Y N Blood Transfusion
Y N Cancer
Y N Chemotherapy
Y N Diabetes
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Eating Disorder
Y N Emphysema
Y N Epilepsy/Seizures
Y N Fainting
Y N Fever Blisters/Herpes
Y N Glaucoma
Y N Hearing Aids
Y N Heart Attack
Y N Heart Surgery
Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis A/B/C
Y N High/Low Blood Pressure
Y N HIV/AIDS
Y N Kidney Problems
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Stroke
Y N Ulcers/Colitis
Y N Venereal Disease

Are you allergic to any of the following:
Y N Amoxicillin
Y N Latex
Y N Penicillin
Y N Sulfa Drugs
Other: _____
_____

Are you pregnant? Yes No

Please list any medication(s) you are currently taking: _____

_____

Please list any other serious medical condition(s) our office should be aware of: _____

_____

Patient's Signature: _____ Date: _____