STRAIT SMILES
FAMILY DENTISTRY

ADULT REGISTRATION

Date_____ Patient Name _____

- ❑ Single
- ❑ Widowed
- ❑ Married
- ❑ Other

Street Address_____

City_____ State_____ Zip_____

Birth date _____ SSN_____

Home Phone_____ Cell Phone_____ Work Phone _____

E-mail Address_____

Do you prefer appointments to be confirmed by a text and/or e-mail? **Yes No Text E-mail**

Patient Employer_____

Business Address_____

Spouse's Name _____ Birth date_____

Spouse's Employer_____ Emp. Phone_____

In case of emergency, please notify_____ Phone_____

Person Responsible for this Account_____

If new patient, whom may we thank for referring you_____

DENTAL INSURANCE INFORMATION

Name of Dental Insurance_____ Group #_____ Employer_____

Name of Subscriber_____ Birth date_____ SSN or ID#_____

Secondary Dental Insurance_____ Group #_____Employer_____

Name of Subscriber_____ Birth date_____ SSN or ID#_____

I hereby authorize payment of dental benefits made directly to the dentist indicated.

_____ _____

Signed (Insured Person) *Date*

DENTAL AND MEDICAL INFORMATION

Date _____ Patient's Name _____

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

DENTAL INFORMATION

Date of last dental visit?_____Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely

Have you ever had any serious trouble associated with previous dental treatment? ❑ **YES** ❑ **NO**

Are you required/did you take medication (as prescribed by American Heart Assoc.) prior to treatment: ❑ **YES** ❑ **NO**

If yes, what are you prescribed and what is the reason for the premedication? _____

_____

Correct responses to the following statements will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

	Yes	***No***		***Yes***	***No***
It is important for me to keep my teeth.	❑	❑	I have had injury to my head, neck or jaw.	❑	❑
I am having dental pain at this time?	❑	❑	I have had:		
I wear a removable dental appliances?	❑	❑	Orthodontic treatment (braces).	❑	❑
I am dissatisfied with the appearance of your teeth?	❑	❑	Oral surgery.	❑	❑
			Your bite adjusted.	❑	❑
Habits:	❑	❑	My are teeth sensitive to:		
I clench my teeth while I am awake or asleep.	❑	❑	❑ Hot ❑ Sweets ❑ Cold ❑ Biting	❑	❑
I bite my lips or cheek frequently?	❑	❑	I experience bad breath/taste.	❑	❑
I smoke or use chewing tobacco?	❑	❑	I get frequent blisters on my lips/mouth.	❑	❑
Has anyone in your family ever had gum treatment?	❑	❑	I have noticed any loosening of teeth.	❑	❑
I have had periodontal treatment? If so, when _____	❑	❑	I have had excessive bleeding following an extraction, and/or cuts take longer to heal.	❑	❑
Food tends to get caught between my teeth.			I get frequent swelling/lumps in mouth.	❑	❑
Problems of the Jaw:			I use the following:		
I do wear or have worn a bite guard appliance.	❑	❑	Toothbrush	❑	❑
I notice clicking of the jaw.	❑	❑	How often do you brush_____		
I notice pain (joint, ear, side of face).			Dental floss	❑	❑
I notice difficulty in opening or closing.	❑	❑	Fluoride rinse	❑	❑
I notice difficulty in chewing.	❑	❑	My gums often bleed while brushing.	❑	❑

MEDICAL INFORMATION

Physician name _____ Date of last physical exam _____

Physician address _____

Are you **currently** under the care of a physician? ❑ **YES** ❑ **NO**

If so, describe _____

Prescription and Non-prescription Drug Information

Please describe any current medical treatment INCLUDING ALL current drugs/medications and the reason you are taking the medication:

_____

_____

_____

Do you have a history of taking drugs for osteoporosis or cancer therapy? ❑ **YES** ❑ **NO**

Commonly used agents:

IV: ❑ pamidronate (Aredia) ❑ zoledronate (Zometa) (Reclast)

STRAIT SMILES
FAMILY DENTISTRY

ORAL: ❑ alendronate (Fosamax) ❑ ibandronate (Boniva) ❑ risedronate (Actonel)

Do you regularly take supplements or herbal medicines? ❑ **YES** ❑ **NO**

If yes, do you regularly take any of the following?
❑ Vitamin E >400 units ❑ Fish Oil >3g ❑ Echinacea ❑ Ephedra ❑Garlic
❑ St. John's Wort ❑ Kava Kava ❑ Ginseng ❑Valerian ❑Ginkgo Biloba

Have you recently stopped taking any herbs? ❑ **YES** ❑ **NO**

Have you substituted any herbs for prescription or over the counter drugs? ❑ **YES** ❑ **NO**

Please describe any pending surgeries, recent injuries or any other information we should be aware of that we have not discussed:

_____

_____

Please answer the following medical condition questions, filling in the blanks when necessary:

	Yes	*No*
I have or I have had the following Cardiovascular Conditions:		
Rheumatic fever	❑	❑
Heart murmur	❑	❑
Congenital heart defect	❑	❑
Heart transplant	❑	❑
Heart surgery/Angioplasty	❑	❑
Vascular disease	❑	❑
Stroke	❑	❑
Pacemaker	❑	❑
Prosthetic heart valve	❑	❑
Heart attack (heart trouble)	❑	❑
High blood pressure	❑	❑
Low blood pressure	❑	❑
Angina	❑	❑
Other cardio problems (describe):_____	❑	❑
Other conditions:		
Liver disease, jaundice	❑	❑
Hepatitis	❑	❑
Diabetes	❑	❑
Kidney trouble, dialysis	❑	❑
Thyroid problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Hay fever	❑	❑
Hives or skin rash	❑	❑
Arthritis, Rheumatism	❑	❑
Joint replacement	❑	❑
Type: _____		
Date: _____		
Orthopedic pins, rods, screws	❑	❑
Prosthetic devices or implants		
Type: _____		
Date: _____	❑	❑
Anemia	❑	❑
Hemophilia or other bleeding disorders	❑	❑
Leukemia	❑	❑
Tuberculosis	❑	❑
HIV infection	❑	❑
AIDS	❑	❑
Venereal disease	❑	❑
Stomach ulcers	❑	❑
Glaucoma	❑	❑
Cancer	❑	❑
Chemical dependency	❑	❑
Problems with mental health	❑	❑
I have or I have had:		
Chest pain upon exertion	❑	❑
Shortness of breath after exercise	❑	❑
Ankle swelling	❑	❑
Shortness of breath lying down	❑	❑
Sores in the mouth	❑	❑
White lesions in the mouth	❑	❑
Lumps or tumors in mouth\neck	❑	❑
Persistent diarrhea, nausea, vomiting	❑	❑
Fainting spells	❑	❑
Persistent cough\cough blood	❑	❑
Radiation or chemotherapy	❑	❑
Blood transfusion	❑	❑
Date: _____		
I am allergic to, or I have had any reactions to:		
Local anesthetic (novocaine)	❑	❑
Penicillin, other antibiotics	❑	❑
Barbiturates, sedative, or sleeping pills	❑	❑
Sulfa drugs	❑	❑
Aspirin	❑	❑
Other pain meds	❑	❑
Iodine	❑	❑
Latex gloves	❑	❑
Other: _____	❑	❑
_____	❑	❑
I am or I have taken:		
Antibiotics, sulfa drugs	❑	❑
Antihistamines	❑	❑
Aspirin or other pain meds	❑	❑
Codeine	❑	❑
Dilantin	❑	❑
Insulin/Blood sugar drugs	❑	❑
Blood thinners	❑	❑
Blood pressure medications	❑	❑
Digitalis/Heart drugs	❑	❑
Nitroglycerine	❑	❑
Tranquilizers	❑	❑
Women Only:		
I am pregnant.	❑	❑
I am nursing.	❑	❑
I am on birth control pills.	❑	❑

To the best of my knowledge, the above information is complete and correct. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. *I understand that a 1.5% Service Charge may be assessed on the unpaid balance of 60 days and over, and also liable for legal and collection fees. I understand that I am responsible for payment in full upon completion of each procedure. My insurance will be billed, if applicable, however, I am responsible for all charges not covered by my insurance.*

_____ _____

Signature of patient or parent/guardian *Date*