Patient Registration

How did you learn about our office?

□ Convenient Location □ Newspaper Ad □ Yellow pages (which)? _____ □ Insurance □ Mailing

□ Previous Patient (Name) _____ □ Friends/Family (Name) _____ □ Staff Member (Name) _____

Patient Information

Patient is: □ Policy Holder □ Responsible Party Date: _____

First Name: _____ Last Name: _____

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Ext: _____ Cellular: (_____) _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed

Birth Date: _____ Age: _____

Social Security Number: _____ Driver's License Number: _____

Email: _____ □ I would like to receive correspondences via e-mail.

Employment Status: □ Full Time □ Part Time □ Retired Student Status: □ Full Time □ Part Time

Responsible Party (if someone other than patient)

Name of Person Responsible for this Account: _____

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Ext: _____ Cellular: (_____) _____

Birth Date: _____ Social Security Number: _____ Driver's License Number: _____

□ Responsible Party is also a Policy Holder for Patient □ Primary Insurance Policy Holder □ Secondary Insurance Policy Holder

Signature of Responsible Party: _____

OVER PLEASE

PINNACLE DENTAL GROUP

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security Number: _____ Insured Birth Date: _____

Employer: _____

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Insurance Company: _____

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Remaining Benefits: _____.00 Remaining Deductible: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security Number: _____ Insured Birth Date: _____

Employer: _____

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Insurance Company: _____

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Remaining Benefits: _____.00 Remaining Deductible: _____.00

Patient Dental History

Name: _____ Date _____

Name of Previous Dentist and Location: _____

Date of last exam: _____ Were X-rays taken? ☐ Yes ☐ No

Is there anything about your smile you would like to change or improve?…….. ☐ Yes ☐ No

If yes, what would you like to change? _____

How often do you brush? _____

How often do you floss? _____

Do you use tobacco products? ……. ☐ Yes ☐ No

If yes, what kind? _____ How frequently and for how many years? _____

Do your gums bleed while brushing or flossing?……. ☐ Yes ☐ No

Are your teeth sensitive to hot or cold liquids/foods?…….. ☐ Yes ☐ No

Are your teeth sensitive to sweet or sour liquids/foods?…….. ☐ Yes ☐ No

Do you feel pain to any of your teeth?……. ☐ Yes ☐ No

Do you have any sores or lumps in or near your mouth? …… ☐ Yes ☐ No

Have you had any head, neck or jaw injuries? …… ☐ Yes ☐ No

Have you ever experienced any of the following problems in your jaw:

Clicking? …… ☐ Yes ☐ No

Pain (joint, ear, side of face)? …… ☐ Yes ☐ No

Difficulty in opening or closing? ……... ☐ Yes ☐ No

Difficulty in chewing? …… ☐ Yes ☐ No

Do you have frequent headaches? ……... ☐ Yes ☐ No

Do you clench or grind your teeth? ……. ☐ Yes ☐ No

Do you bite your lips or cheeks frequently? …… ☐ Yes ☐ No

Have you ever had any difficult extractions in the past? ……. ☐ Yes ☐ No

Have you ever had any prolonged bleeding following extractions? …… ☐ Yes ☐ No

Have you had any orthodontic treatment? …… ☐ Yes ☐ No

Have you had any periodontal (gum disease) treatment? ……. ☐ Yes ☐ No

Do you wear dentures or partials? …… ☐ Yes ☐ No

If yes, date of placement _____

Have you ever received instructions regarding the care of your teeth and gums? ☐ Yes ☐ No

Medical History

Patient Name: _____ Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No ☐ N/A _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No ☐ N/A _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No ☐ N/A _____

Are you taking any medications, including non-prescription drugs? ☐ Yes ☐ No ☐ N/A

If Yes, please list the medications you are taking. _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No ☐ N/A _____

Do you or have you had a problem with alcohol or drug abuse? ☐ Yes ☐ No ☐ N/A _____

Do you use or have you used tobacco products? ☐ Yes ☐ No ☐ N/A _____

Are you on a special diet? ☐ Yes ☐ No ☐ N/A _____

Women Are you: ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic or have you had a reaction (swelling, rash, itching) to any of the following?

☐ Aspirin ☐ Penicillin or other antibiotics ☐ Codeine ☐ Acrylic
☐ Metals/Jewelry ☐ Latex/rubber products ☐ Local anesthetics ☐ Other _____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimier's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital heart Disorders	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsilitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you had any serious illness not listed above? ☐ Yes ☐ No ☐ N/A _____

Comments: _____
_____
_____

*Condition may require medication N/A – Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

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