

Patient Registration Form

MARIETTA DENTAL PROFESSIONALS

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth(Age)		Social Security Number	
Patient's Address			City	State	Zip
Home Phone		Mobile Phone		Email Address	
Referred by					

Patient Employer/School Information

Employer/School		Occupation	Employer/School Phone		
Employer/School Address			City	State	Zip

Emergency Contact Information

Emergency Contact Name		Emergency Contact Phone	Relation to Patient
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Billing and Insurance

Primary Dental Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School			
Insured's Name(as it appears on insurance card or ID)		Relation to Patient		Insured's Phone Number	
Insured's Address		City	State	Zip	
Insured's Social Security Number	Insured's Birthdate				

Secondary Dental Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School		Insured's Social Security Number	
Insured's Name(as it appears on insurance card or ID)		Relation to Patient		Insured's Phone Number	

Responsible Party

Billing Name (if other than patient)		Phone	Relation to Patient		
Address		City	State	Zip	

Signature of Patient or Authorized Guardian

Date

Date of Appointment: _____

Name _____ Gender _____ Age _____

Reason for Visit

What brings you to the office?

Current Medications

Are you currently taking any blood thinners?
 Yes No

What medications are you currently taking?

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dental History

When was your last dental exam?
Date _____

When were your last dental x-rays taken?
Date _____

How often do you brush? _____ How often do you floss? _____
#times/day #times/day

Do you grind your teeth?
 Yes No

Have you ever had orthodontic (braces) treatment?
 Yes No

Allergies

Are you allergic to any of the following?

<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Latex
<input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Iodine
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa	<input type="checkbox"/> LocalAnesthetics

Do you have any other allergies?

Name	Reaction
_____	_____
_____	_____

Hospitalizations & Surgeries

Reason	Date
_____	_____
_____	_____
_____	_____

Past Medical History

Have you ever had any of the following?

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Migraines	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Allergies	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Joint Disorder	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Bowel Disorder	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis-A,B,orC	<input type="checkbox"/> Lupus	<input type="checkbox"/> Skin Disorder	
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke	

Lifestyle Factors

Have you ever smoked?
 Yes No #of years _____ #packs/day _____

Do you smoke now?
 Yes No #packs/day _____

Do you use recreational drugs?
 Yes No types? _____ #times/week _____

How much alcohol do you drink per week?
#drinks/week _____

How much caffeine do you drink per day?
#drinks/day _____

Women Only

Are you pregnant? Yes No

Are you breastfeeding? Yes No

What is your method of birth control?
