PATIENT REGISRATION

TODAYS DATE:		
NAME:		
BIRTHDATE:	**AGE:**	**SS#:**
HOME ADDRESS:		
EMAIL:		
☐ **SINGLE** ☐**MARRIED** ☐**DIVORCED** ☐**WIDOWED**		
CELL#: **HM#**		
WORK#: **EXT:** **DL:**		
OCCUPATION:		**HOW LONG THERE?**
HOW DID YOU HEAR ABOUT US?		

DENTAL INSURANCE

INSURANCE CO NAME: **INSURANCE CO PHONE#**

GROUP # (Plan, Local, Policy#):

INSURED'S NAMES: **INSURED'S DOB:** **INSURED'S SS#:**

DO YOU WANT PRE-APPROVAL FOR NO DOWN PAYMENT FINANCING? YES or NO

MEDICAL & DENTAL HISTORY

Dentist Name: _____

Last Cleaning:

Physicians Name: _____

Have you had an orthodontic evaluation in the last 2 years? If yes, please specify:

Is medication required before dental procedures? If yes, please specify:

Are you under the care of a physician?

Are you taking medication at this time? If yes, specify:

Do you have any drug allergies? If yes, please specify:

Is there anything else we should know about your medical history?

Patient Signature: _____

PATIENT HAS A HISTORY OF….

☐ ALLERGIES ☐ HIGH BLOOD PRESSURE

☐ ASTHMA ☐ LATEX ALLERGY

☐ BLOOD DISEASE ☐ TRAUMATIC INJURY

☐ BONE DISORDER ☐ RHEUMATIC FEVER

☐ DIABETES ☐ OTHER _____

☐ ENDOCRINE PROBLEMS

☐ EPILEPSY