Patient Registration Form

PURE SMILES DENTISTRY

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

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?

Allergies

Are you allergic to any of the following?

- [ ] Adhesive Tape
- [ ] Antibiotics
- [ ] Latex
- [ ] Barbiturates (Sleeping Pills)
- [ ] Aspirin
- [ ] Iodine
- [ ] Codeine
- [ ] Sulfa
- [ ] LocalAnesthetics

Do you have any other allergies?

Name | Reaction

Name | Reaction

Current Medications

Are you currently taking any blood thinners?

- [ ] Yes
- [ ] No

What medications are you currently taking?

Name | Dosage | Frequency

Name | Dosage | Frequency

Name | Dosage | Frequency

Hospitalizations &Surgeries

Reason | Date

Reason | Date

Reason | Date

Dental History

When was your last dental exam?

Date____________

When were your last dental x-rays taken?

Date____________

How often do you brush?

#times/day____________

How often do you floss?

#times/day____________

Do you grind your teeth?

- [ ] Yes
- [ ] No

Have you ever had orthodontic (braces) treatment?

- [ ] Yes
- [ ] No

Have you ever had periodontal (gum) treatments?

- [ ] Yes
- [ ] No

Do you have any of the following?

- [ ] Bad Breath
- [ ] Dry Mouth
- [ ] Partials
- [ ] Bleeding Gums
- [ ] Difficulty Chewing
- [ ] Sensitivity to Cold
- [ ] Blisters on Mouth
- [ ] Ear Pain
- [ ] Sensitivity to Heat
- [ ] Broken Fillings
- [ ] Jaw Pain
- [ ] Sensitivity to Sweets
- [ ] Clicking Jaw
- [ ] Loose Teeth
- [ ] Sensitivity to Pressure
- [ ] Dentures
- [ ] Mouth Pain
- [ ] Swollen Gums
- [ ] Difficulty Opening or Closing
- [ ] Mouth Sores

Past Medical History

Have you ever had any of the following?

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

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?