PACIFIC DENTAL CENTER

Dental Registration

PATIENT INFORMATION	DENTAL INSURANCE / FINANCIAL RESPONSIBLITY
Date: _____	Who is Responsible for this Account:
Patient Name: _____	Subscriber: _____
Preferred Name: _____	Relationship to Patient: _____
Address: _____	Insurance Co: _____
City: _____	Group #: _____
State: _____ Zip Code:_____	Subscriber Name: _____
Date of Birth: _____	Date of Birth: _____ SS#: _____
Social Security Number: _____-_____-_____	Secondary Insurance: _____
Gender: _____ Age:_____	Relationship to Patient: _____
Marital Status: _____	Insurance Co: _____
Spouses Name: _____	Group #: _____
Employer / School: _____	Subscriber Name: _____
Occupation: _____	Date of Birth: _____ SSN#: _____
Who Referred You: _____	

CONTACT INFORMATION	
Home Phone: _____	Work Phone: _____
Cell Phone: _____	Email: _____
In Case of Emergency:	
Name: _____	Relationship: _____
Home: _____	Cell: _____

Dental Registration

Dental History:

Reason for today's visit:_____

Former Dentist: _____ Last Dental Visit" _____

Do you have any of the following?

Bad Breath	YES NO	Bleeding Gums	YES NO
Blisters on Lips / Mouth	YES NO	Burning Sensation on Tongue	YES NO
Use Tobacco Products	YES NO	Clicking/Popping Jaw	YES NO
Dry Mouth / Mouth Breathing	YES NO	Fingernail Biting	YES NO
Grinding / Clench Teeth	YES NO	Swollen / Tender Gums	YES NO
Lip / Cheek Biting	YES NO	Loose Teeth / Broken Fillings	YES NO
Teeth Sensitivity	YES NO		

How often do you floss? _____ Brush? _____

Health History:

Physician's Name: _____ Phone Number: _____

Do you have any of the following?

AIDS / HIV	YES NO	Epilepsy	YES NO	Pacemaker	YES NO
Anemia	YES NO	Fainting / Dizziness	YES NO	Psychiatric Care	YES NO
Arthritis	YES NO	Glaucoma	YES NO	Radiation Treatment	YES NO
Artificial Heart Value	YES NO	Headaches	YES NO	Respiratory Disease	YES NO
Artificial Joints	YES NO	Heart Murmur	YES NO	Rheumatic Fever	YES NO
Asthma	YES NO	Heart Problems	YES NO	Scarlet Fever	YES NO
Back Problems	YES NO	Heart Attack	YES NO	Shortness of Breath	YES NO
Bleeding Problems	YES NO	A Fib	YES NO	Sinus Troubles	YES NO
Blood Disease	YES NO	Tachycardia	YES NO	Skin Rash	YES NO
Cancer	YES NO	Hepatitis Type:	YES NO	Special Diet	YES NO
Chemical Dependency	YES NO	Herpes	YES NO	Stroke	YES NO
Chemotheraphy	YES NO	High Blood Pressure	YES NO	Swollen Feet / Ankles	YES NO
Circulatory Problems	YES NO	Jaundice	YES NO	Swollen Neck Glands	YES NO
Congenital Health Lesions	YES NO	Jaw Pain	YES NO	Thyroid Problems	YES NO
Cortisone Treatments	YES NO	Kidney Disease	YES NO	Tonsillitis	YES NO
Persistent Cough	YES NO	Liver Disease	YES NO	Tuberculosis	YES NO
Diabetes	YES NO	Low Blood Pressure	YES NO	Growth on Head / Neck	YES NO
Emphysema	YES NO	Mitral Valve Prolapse	YES NO	Ulcer	YES NO
Unexplained Weight Loss	YES NO	Nervous Problems	YES NO	Venereal Disease	YES NO
Women: Are you pregnant	YES NO	Nursing:	YES NO	Taking Birth Control:	YES NO

Dental Registration

Medications:	Allergies:	
List any medications you are currently taking and the correlating diagnosis _____ _____ _____	Aspirin	YES NO
	Barbiturates (Sleeping Pills)	
	Codeine	
	Iodine	
	Latex	
	Local Anesthetic	
	Penicillin	
	Sulfa	
	Other (Please List)	
Pharmacy:		

Signatures:
To the best of my knowledge the information provided on this for is complete and correct. I understand that it is responsibility to inform my doctor if myself or my child has a change in health. Signature of Parent / Guardian/ Self: _____ Print Name: _____ Relationship: _____ Date: _____