PATIENT REGISTRATION

TODAY'S DATE ___________

Patient's Name	**Birth date**		**Age**	**Sex:** M F
Home Address	**City**	**State**	**Zip**	
Home Phone # **Cell#**	***Please Circle One:*** Single, Married, Separated, Widow		**Patient Social Security Number**	
Patient's Employer	**Occupation**		**Work Phone #**	
Are you a full time student? ☐Yes ☐No	*If patient is minor we need Mother & Father's Names, SSN & Birth date*			
Person responsible for account:	**Patient's Driver's License Number:**			
Name of spouse (or parent if minor)	**Patient's E-mail address**			
Spouse's (or parent's) employer	**Spouse's Soc. Sec. #**		**Work phone #**	
EMERGENCY INFORMATION				
Name, Address, & Telephone of A relative not living with you:				
How did you hear about our office?				
Reason for this visit?				
For your convenience, we offer the follwing methods of payment. Please check the option you prefer: **Payment in full at each visit.** ☐ Cash ☐Check ☐Dental Credit Card ☐Credit Card				

DENTAL INSURANCE INFORMATION (Primary)			**If you have a dual insurance coverage complete this for the second coverage**		
Subscriber name	**DOB**	**SS#**	Subscriber name	DOB	SS#
Subscriber employer			Subscriber employer		
Insurance Co			Insurance Co		
Insurance Co Address			Insurance Co Address		
Phone #			Phone #		
Group #	**Policy #**		Group #		Local #

DENTAL HISTORY

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches,ear aches, neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain
- ☐ Broken tooth or fillings
- ☐ Food catching between teeth
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifted teeth
- ☐ Bad breath or bad taste in your mouth

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

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Gum treatments

Please share the following dates:

Your last cleaning ______/______

Your last oral cancer screening ______/______

Your last complete x-rays ______/______

Name of Previous Dentist:

____

City: ______________ State: ______________

Phone number: ______________________

What is the most important thing to you about your future smile and dental health?

____

____

____

____

____

If you could whiten your teeth for a cost anyone could afford, would you do it?

____

Do you smoke or use chewing tobacco? _______

How much? For how long?

____

If you could change your smile, you would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns thet don't match
- ☐ Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your **current** dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

____

____

____

What is the most important thing to you about your dental visit today?

____

____

____

____

____

THE LODI DENTIST

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

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.

Question			
Are you under a physician's care now?	Yes No	If yes	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		
Do you use controlled substances?	Yes No	If yes	

Women: Are you...

- Pregnant/Trying to get pregnant?
- Nursing?
- Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics

Other? If yes

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No	Anemia	Yes No
Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No	Angina	Yes No
Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No	Arthritis/Gout	Yes No
Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No	Artificial Heart Valve	Yes No
Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No	Artificial Joint	Yes No
Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No	Asthma	Yes No
Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No	Blood Disease	Yes No
Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No	Blood Transfusion	Yes No
Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No	Breathing Problems	Yes No
Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No	Bruise Easily	Yes No
Low Blood Pressure	Yes No	Swelling of Limbs	Yes No	Cancer	Yes No	Glaucoma	Yes No
Lung Disease	Yes No	Thyroid Disease	Yes No	Chemotherapy	Yes No	Hay Fever	Yes No
Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No	Chest Pains	Yes No	Heart Attack/Failure	Yes No
Osteoporosis	Yes No	Tuberculosis	Yes No	Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No
Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No	Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No
Parathyroid Disease	Yes No	Ulcers	Yes No	Convulsions	Yes No	Heart Trouble/Disease	Yes No
Psychiatric Care	Yes No	Venereal Disease	Yes No	Yellow Jaundice	Yes No		

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

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:

X

Date:__________

Signature

Signature of Doctor Yes No