2409 Fairoak Drive • Fort Wayne, IN 46809 • (260) 747-5745

REGISTRATION INFORMATION

Please Fill out ALL lines. *If you need help ask us for assistance.* Date________________

PLEASE PRINT

PATIENT INFORMATION

Last Name: ____________________________ LEGAL First Name: _____________________ Middle Initial: ______

Preferred or "Nickname": ____ Sex: Male or Female (circle one)

Home #: ( ) ______- ___________ Work #: ( ) ______- ___________ Cell #: ( ) ______- ___________

Street:______________________________City:_______________________________ State:_____ Zip:_________

Employer: __________________________________ Email: ____

Work Phone #:____________________________________ Social Security #:__________-__________-__________

Name of School:______________________________ Birthday Month:___________ Day: ________Year:______

Patients relationship to the Responsible Party: SAME SPOUSE CHILD OTHER: ________________(circle one)

Patients Doctor:____

RESPONSIBLE PARTY

(Print name of person who will receive this statement)

Last Name: ___________________________________ LEGAL First Name: ____________________________

Street: ____

City:_______________________________________ State:__________________________ Zip: _______________

Employer: ____

Home Phone:_________________________________ Work Phone: __________________________________

Social Security #:__________-__________-__________ Birthday Month:___________ Day:_______Year:______

EMERGENCY

(Print name of person to contact in case of office emergency)

Name:______________________________________ Phone # (office):_______________ Home: ___________

Street Address: ____

City:_______________________________________ State:____________________ Zip: ___________________

PRIMARY DENTAL INSURANCE POLICY HOLDER

(Print name of person who will receive this statement) - Holder

Last Name: ___________________________________ LEGAL First Name: ____________________________

POLICY HOLDER'S INSURANCE COMPANY INFORMATION

EMPLOYER'S NAME: ____

Insurance Company:____

Claim Address: ____

Phone #: ______ ______ - ______________

Policy Number (if any):____________________________ Group Number (if any):_________________________

Union Local (if any):______________________________ SSN # of policy holder: _______________________

Do you have any secondary insurance? ☐ Yes ☐ No

PRESENT CARD →

- OVER PLEASE -

PERSON WHO REFERRED YOU TO OUR OFFICE

Name: ____

Medical History

Have you had or do you have any of the following?

YES	NO	
☐	☐	Artificial Joint Replacement - Pre-Med Y / N
☐	☐	Heart Murmur - Pre-Med Y / N
☐	☐	Heart Valve Replacement - Pre-Med Y / N
☐	☐	Mitral Valve Prolapse - Pre-Med Y / N
☐	☐	Bleeding Disorder
☐	☐	Rheumatic Fever
☐	☐	Hepatitis
☐	☐	Liver Dysfunction
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Anemia
☐	☐	Asthma
☐	☐	Lung Disease (TB)
☐	☐	Allergies
☐	☐	Stroke
☐	☐	Arthritis
☐	☐	Kidney Disease
☐	☐	Gout
☐	☐	Glaucoma
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	AIDS/HIV
☐	☐	Tattoo / Pierciings
☐	☐	Osteoporosis Medication ☐ Yes ☐ No If Yes please list____________________
☐	☐	HPV (Human Papilloma Virus)
☐	☐	Family History of Oral Cancer

Are you allergic to?

YES	NO	
☐	☐	Penicillin
☐	☐	Codeine
☐	☐	Aspirin
☐	☐	Sulfa
☐	☐	Local Anesthetics
☐	☐	Other Medication
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Nitrous Oxide

Vaccines ☐ HPV ☐ Hepatitis

Are you presently taking any medication? if so, please list.

____

____

List any conditions of which you are aware that have not been mentioned. ______________________________

____

____

Do you use tobacco products? ☐ Yes ☐ No

If yes, ☐ smokeless ☐ cigarette ☐ cigar/pipe

(Women) Are you pregnant? ☐ Yes ☐ No

Dental History

Name and address of your previous dentist: ____

Reason for leaving previous dentist:____

When was your last visit?______________________ Last X-Rays?_____________________________

What was done at that time? ____

Are you satisfied with the appearance of your teeth?____________________________________

How often do you brush?______________________ Floss? ____________________________

YES	NO	
☐	☐	Do you use a soft toothbrush?
☐	☐	Water Pik?
☐	☐	Do your gums bleed?
☐	☐	Do you have pain or soreness in teeth or gums?
☐	☐	Are your teeth sensitive to sweets? temperature? pressure?
☐	☐	Do you notice popping or clicking in your jaw?
☐	☐	Do you clench or grind your teeth?
☐	☐	Have you had any teeth removed?
☐	☐	Have you had orthodontic treatment? (Braces)
☐	☐	Have you had periodontic treatment? (gum treatment)
☐	☐	Have you had dental implants?

List any dental conditions of which you are aware that has not been mentioned. ____________________

____

Do you have a dental problem which you believe requires immediate attention? ____________________

____

DATE ______________ **PATIENT SIGNATURE**____