Patterson
FAMILY SMILES

Dental Registration

PATIENT INFORMATION

Date _____ Social Security# _____

Patient Name _____
Last Name First Name Middle Inital

Address _____ City _____ State _____ Zip _____

E-mail _____ Sex (Circle One) M F Age _____ Birthdate _____

Circle One: Married Widowed Single Minor

Patient Employer/School _____ Occupation _____

Employer School/Address _____ Employer School/Phone (_____) _____

Spouse's Name _____ Birthdate _____

Spouse's Social Security# _____ Spouse's Employer _____

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____

Cell Phone (_____) _____ Spouse's Work (_____) _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY CONTACT (Specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

Please circle referral source:

Friend
Family
Internet - Google, Bing, etc.
Drove By
Local Magazine
Other _____

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Medical History

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!

Are you under a physician's care now?	YES	NO	If yes, please explain _____
Have you ever been hospitalized or had a major operation?	YES	NO	If yes, please explain _____
Have you ever had a serious head or neck injury?	YES	NO	If yes, please explain _____
Are you taking any medications, pills or drugs?	YES	NO	If yes, please explain _____
Do you take, or have you taken, Phen-Fen or Redux?	YES	NO	If yes, please explain _____
Are you on a special diet?	YES	NO	If yes, please explain _____
Do you use tobacco?	YES	NO	
Do you use controlled substances?	YES	NO	
Are you experiencing pain or discomfort?	YES	NO	
Are you in good health?	YES	NO	

Women:

Are you pregnant or trying to get pregnant?	YES	NO
Taking oral contraceptives?	YES	NO
Nursing?	YES	NO

Are you allergic to any of the following? (Please Circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

If other, please list _____

Do you have, or have had, any of the following (Please Circle) _____

AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problem
Bruise easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Emphysema
Epilepsy or Seizures
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pace Maker
Heart Trouble/Disease
Hemophilia
Hepatitis A, B or C
Herpes
High Blood Pressure
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Pain Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatments
Renal Dialysis
Rheumatic Fever
Rheumatism
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice

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DENTAL HISTORY

Reason for today's visit _____

Please **circle** to indicate if you have had any of the following:

Former Dentist (Optional) _____ City/State _____

Date of last dental visit _____ Date of last dental X-rays _____

Dental Anxiety 0 (None) <⟶> 10 (Max): _____

Past Dental Experience (Circle One) Excellent Positive Neutral Negative Horrible

Bad Breath	Dry Mouth	Lip or cheek biting	Sensitivity to cold
Bleeding Gums	Fingernail Biting	Loose teeth or broken fillings	Sensitivity to hot
Blisters on lips or mouth	Food collection between teeth	Mouth breathing	Sensitivity to sweets
Burning sensation on tongue	Foreign Objects	Mouth pain, brushing	Sensitivity when biting
Chew on one side of mouth	Grinding Teeth	Orthodontic treatment	Sores or growths in your mouth
Cigarette, pipe or cigar smoking	Gums Swollen or tender	Pain around ear	
Clicking or popping jaw	Jaw pain or tiredness	Periodontal treatment	

Please circle 'YES' or 'NO' to indicate if you have had any of the following:

Does food get caught in your teeth?	YES	NO
Do you have frequent headaches, neck aches, or shoulder aches?	YES	NO
Do you clench or grind your teeth?	YES	NO
Have you experienced any pain or soreness in the muscles of your face or around your ear or jaw TMJ/TMD?	YES	NO
Does your jaw click or pop?	YES	NO
Have you ever had or been evaluated for orthodontic treatment before?	YES	NO
Do you have any missing or extra permanent teeth?	YES	NO

How often do you floss? _____ How often do you brush? _____

Do any of your teeth hurt?	YES	NO

If so, please explain _____

Are you taking any medications to treat osteoporosis such as Fosmax, Aredia, Boniva, Zometa (Bisphosphonates) or Herbal remedies?	YES	NO
Is there anything about your teeth or smile you would like to change, such as dark teeth, crooked teeth, unsightly silver fillings, gummy smile,underbite, overbite, etc?	YES	NO

If so, please explain _____

Have you had any serious trouble associated with any previous dental treatment?	YES	NO

If so, please explain _____

Have you ever had an injury to your (please circle)

Is there anything you would like the dentist to know? _____