TODAY'S DATE_____

ADVANTAGE DENTAL

PATIENT REGISTRATION

PATIENT INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	NICKNAME OR PREFERRED NAME
EMAIL			
ADDRESS			BIRTHDATE
CITY	STATE	ZIP	☐ MALE ☐ MARRIED ☐ FEMALE ☐ SINGLE
HOME PHONE ☐ PREFERRED	CELL PHONE ☐ PREFERRED	WORK PHONE ☐ PREFERRED	SOCIAL SECURITY NUMBER

IF PATIENT IS A MINOR, PROVIDE THE FOLLOWING	PARENT/LEGAL GUARDIAN FIRST NAME LAST NAME		RELATIONSHIP TO PATIENT ☐ PARENT ☐ GRANDPARENT ☐ OTHER ☐ LEGAL GUARDIAN	
	EMAIL ADDRESS			
	ADDRESS ☐ SAME AS ABOVE	CITY	STATE	ZIP
HOME PHONE ☐ PREFERRED	CELL PHONE ☐ PREFERRED	WORK PHONE ☐ PREFERRED	SOCIAL SECURITY NUMBER	
WITH WHOM DOES THE CHILD RESIDE? ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER (PLEASE SPECIFY)_____				

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT PERSON	PHONE NUMBER	RELATIONSHIP
NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU	PHONE NUMBER	RELATIONSHIP

THE BIGGEST COMPLIMENT OUR PATIENTS CAN GIVE US IS THE REFERRAL OF FAMILY & FRIENDS

WHOM MAY WE THANK FOR REFERRING YOU? PLEASE PROVIDE FULL NAME	ARE THEY A PATIENT HERE? ☐ YES ☐ NO – CHOOSE BELOW
HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ OUR WEBSITE ☐ BUILDING SIGN ☐ YOUR EMPLOYER ☐ MAILER/UNION HALL ☐ PUBLIC EVENT ☐ INSURANCE COMPANY ☐ ONLINE SEARCH ☐ SOCIAL MEDIA ☐ DENTAL CENTER EMPLOYEE_____	

IF YOU HAVE DENTAL INSURANCE, PLEASE PROVIDE THE FOLLOWING & YOUR INSURANCE CARD

PRIMARY CARRIER

INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE
PRIMARY INSURED NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER
INSURED SOCIAL SECURITY	
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME

SECONDARY CARRIER

INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE
PRIMARY INSURED NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER
INSURED SOCIAL SECURITY	
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME

ADVANTAGE DENTAL

PATIENT NAME_____

MEDICAL HISTORY

The following questions are for your benefit and assure that any dental treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care. Please answer each question.

1. Have you taken any medication or drugs during the past two years? ☐ YES ☐ NO
2. Are you currently taking any medication, drugs, pills or herbal remedies, including dosages of aspirin? ☐ YES ☐ NO
   If YES, please list name and dosage_____
3. Are you sensitive or allergic to any substance(s) or medication? ☐ YES ☐ NO
   If YES, please check all that apply ☐Aspirin ☐ Codeine ☐ Darvon ☐ Demerol ☐ Erythromycin ☐ Latex ☐ Nitrous Oxide
   ☐ Penicillin ☐ Percodan ☐ Sulfa Drugs ☐ Tetracycline ☐ Valium ☐ Vicodin ☐ Metals ☐ Other_____
4. Have you ever taken prescription medications for weight loss (diet pills)? ☐ YES ☐ NO
   If YES, did you take any of the following: ☐ Fen-Phen ☐ Pondimen ☐ Redux ☐ Other_____
5. Have you ever taken osteoporosis or bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ☐ YES ☐ NO
6. Have you been a patient in the hospital during the past five years? ☐ YES ☐ NO
7. Have you ever had a serious injury to your head or mouth? ☐ YES ☐ NO
8. Have you ever been told to take a pre-medication prior to dental treatment? ☐ YES ☐ NO
9. Is there anything else about having dental treatment that you would like us to know? ☐ YES ☐ NO
   Please explain_____
10. Have you lost or gained more than 10 pounds in the past year? ☐ YES ☐ NO
11. Do you have, or have you had any disease, condition, or problem not listed? ☐ YES ☐ NO
12. If, please list_____
13. Indicate which of the following you have had, or have at present. Check "YES" or "NO" to each item.
    NOTE: Certain medical conditions may require a medical consultation with your primary care physician prior to the start of any dental treatment.

	YES	NO		YES	NO		YES	NO
A.I.D.S./H.I.V. Positive	☐	☐	Diabetes	☐	☐	Mitral Valve Prolapse	☐	☐
Anemia	☐	☐	Diet (Special/Restricted)	☐	☐	Nervous Disorders	☐	☐
Arthritis/Rheumatism	☐	☐	Difficulty Swallowing	☐	☐	Nervousness/Anxiety	☐	☐
Artificial Heart Valve/Pacemaker	☐	☐	Drug Addiction	☐	☐	Neurological Disorders	☐	☐
Artificial Joints	☐	☐	Emphysema	☐	☐	Osteoporosis	☐	☐
Artificial Prosthesis	☐	☐	Epilepsy or Seizures	☐	☐	Psychiatric/Psychological Care	☐	☐
Asthma	☐	☐	Excessive Bleeding	☐	☐	Radiation Therapy	☐	☐
Blood Disease or Bleeding Disorder	☐	☐	Fainting or Dizzy Spells	☐	☐	Rheumatic Fever	☐	☐
Blood Transfusion	☐	☐	Glaucoma	☐	☐	Scarlet Fever	☐	☐
Bruise Easily	☐	☐	Hay Fever/Allergy/Hives	☐	☐	Sickle Cell Anemia	☐	☐
Cancer, Tumors, Growths	☐	☐	Head Injuries	☐	☐	Sinus Trouble	☐	☐
Cerebral Palsy	☐	☐	Heart Attack, Disease, Surgery	☐	☐	Stroke	☐	☐
Chemotherapy	☐	☐	Heart Failure	☐	☐	Swollen Ankles	☐	☐
Chest Pain	☐	☐	Heart Murmur	☐	☐	Thyroid Problems/Disease	☐	☐
Chicken Pox	☐	☐	Hemophilia	☐	☐	Tonsillitis	☐	☐
Chronic Cough	☐	☐	Hepatitis A B C (CIRCLE WHICH ONE)	☐	☐	Tuberculosis	☐	☐
Cold Sores/Fever Blisters	☐	☐	Herpes	☐	☐	Ulcers	☐	☐
Congenital Heart Disease	☐	☐	High Blood Pressure	☐	☐	Venereal Disease	☐	☐
Contact Lenses	☐	☐	Low Blood Pressure	☐	☐	Kidney Infection or Disease	☐	☐
Cortisone Medicine	☐	☐	Liver Disease/Jaundice	☐	☐	Other _____		

WOMEN

14. Are you pregnant or think you could be pregnant? ☐ YES _____ Months ☐ NO Are you currently nursing? ☐ YES ☐ NO
15. Do you use birth control prescriptions? ☐ YES ☐ NO
16. Do you have any problems associated with your menstrual period? ☐ YES ☐ NO

I have answered all questions to the best of my knowledge. Should further information be needed, I grant permission to ask my respective healthcare providers or agencies, who may release information to you. I will notify the dentist of any changes in my health or medication.

PATIENT SIGNATURE DATE DENTIST REVIEW SIGNATURE *(NON-EHR)* DATE

HISTORY REVIEW DATE _____ /_____ /_____

PATIENT: Any changes to your health history?
☐ NO ☐ YES – If yes, describe changes below

DENTIST: Patient history reviewed.

SIGNATURE *(NON-EHR)* DATE

HISTORY REVIEW DATE _____ /_____ /_____

PATIENT: Any changes to your health history?
☐ NO ☐ YES – If yes, describe changes below

DENTIST: Patient history reviewed.

SIGNATURE *(NON-EHR)* DATE

HISTORY REVIEW DATE _____ /_____ /_____

PATIENT: Any changes to your health history?
☐ NO ☐ YES – If yes, describe changes below

DENTIST: Patient history reviewed.

SIGNATURE *(NON-EHR)* DATE

ADVANTAGE DENTAL

PATIENT NAME_____

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care, please complete both sides of this dental & medical history form. All information is completely confidential and subject to all applicable laws.

Have you had the following disease or problems? **Active Tuberculosis** ☐ YES ☐ NO **Cough that produces blood** ☐ YES ☐ NO
IF YOU ANSWER YES TO EITHER OF THE QUESTIONS ABOVE, PLEASE STOP AND RETURN THIS FORM TO THE RECEPTIONIST.

What is the reason for your visit today?_____

_____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning**_____ **Last Full-Mouth X-rays**_____

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

Are any of your teeth sensitive to…?	YES	NO
Hot or Cold?	☐	☐
Sweets?	☐	☐
Biting or Chewing?	☐	☐

Have you noticed or experienced…?	YES	NO
Mouth odors or bad tastes?	☐	☐
Cold cores, blisters, or other mouth lesions?	☐	☐
Bleeding or painful gums?	☐	☐
Loose teeth or changes in your bite?	☐	☐
Does food tend to get caught between your teeth?	☐	☐

Have you ever had…?	YES	NO
Orthodontic Treatment?	☐	☐
Do you wear a retainer?	☐	☐
Oral Surgery?	☐	☐
Periodontal Treatment?	☐	☐
Your teeth or bite adjusted?	☐	☐
A full/partial denture?	☐	☐
How old is it?	_____	
A mouth guard?	☐	☐
How old is it?	_____	

Do You…?	YES	NO
Clench or grind your teeth while awake or asleep?	☐	☐
Bite your cheeks, lips or fingernails regularly?	☐	☐
Hold foreign objects with your teeth? (i.e., pens, pipe, nails)	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Have tired jaws especially in the morning?	☐	☐
Snore or have any other sleeping disorders?	☐	☐
Smoke/chew tobacco or use other tobacco products?	☐	☐
Drink coffee or tea?	☐	☐

If you could change your teeth…?	YES	NO
Whiter?	☐	☐
Straighter?	☐	☐
Remove space?	☐	☐
Replace metal fillings w/ tooth colored fillings?	☐	☐
Repair chipped teeth?	☐	☐
Replace missing teeth?	☐	☐
Replace old crowns that don't match?	☐	☐
Less gums showing?	☐	☐

	YES	NO
Do you feel nervous about dental treatment?	☐	☐

	YES	NO
Are you satisfied with your teeth appearance?	☐	☐

If so, what's your biggest concern?_____

_____

_____

_____

Have you had any medical care within the past two years? ☐ YES ☐ NO

Physician's Name_____ Phone (_____)_____

Describe_____

_____