Patient Registration

Welcome to our office. Providing you the best dental care possible is our primary goal. The following questionnaire will help us to serve you most efficiently and to obtain the best benefits from any insurance plans. We look forward to working with you, your family and friends for many years to come.

-Dr. Ra and the entire staff-

Who may we thank for referring you to our office?

____

Patient's Name____ Date: ______________

PATIENTS INFORMATION

Street Address: ________________________________ City____________________
State: ________ Zip Code: ______________
Age: _____ Date of Birth: ____________ Sex_______ Social Security # ____________________
Home Phone Number: ________________________ Cell: ________________________
E-Mail Address: ____
Drivers License Number: ______________________________________
Employer: ____________________________ Occupation: ____________________
Employer's Address: ____
Employers Phone Number: ______________________________________
Are you a full time student? If yes please name school: ______________________
Name of Spouse: ___________________________ Cell: ______________________
Children& Age: ____________________ ____________________
Children & Age: ____________________ ____________________

Notify in emergency: ____
Name Relationship Phone Number
Patient's hobbies and special interests: __________________________________

PATIENT/GUARANTOR AND INSURANCE INFORMATION

Who is financially responsible for this Patient?

____
Name Relationship Signature

Primary Dental Insurance Coverage Information
Insured Name: ___________________________Insured Date of Birth: ______________
Insured Social Security #______________________
Name of Insurance Company ______________________________________
Insurance Address______________________ Employer: ______________________
Insurance Phone_______________________ Employer's Address________________
Plan / ID Number ______________________ Employer's Phone __________________
Relationship to the Patient ___________________________________

Secondary Dental Insurance Coverage Information
Insured Name: ___________________________ Insured Date of Birth: ______________
Insured Social Security #______________________
Name of Insurance Company ___________________ Employer ______________________
Insurance Address ______________________ Employer Address __________________
Insurance Phone _______________________ Employer's Phone __________________
Plan / ID Number: ______________________
Relationship to the Patient ___________________________________

Children's Dental and Medical History

DATE ____________

We want to make your children's experience the best ever! This detailed health review will help us to get to know them better and to understand their needs, concerns and goals for treatment. Please feel free to ask any of us to help with questions that may arise while working on this evaluation. *– Dr. Ra*

Child's Name *Age* *Sex* *Height* *Weight* *Social security number*

Parent's Name *Social Security number*

Please detail the CURRENT DENTAL PROBLEMS: ________________________________

____

________________________________ Fever? ____________ How long? ____________

Last dentist name/address: ________________________________

Date of last dental visit: ____________ What was done then? ____________

Physician name/address: ________________________________

Date of last physical exam: ____________ Under treatment NOW? ____________

Have there been cavities? ____________ Gum problems? ____________

Have they lost many teeth? ____________ Why? ____________

Where did they live before age 12? ____________ Was the water fluoridated? ____________

How often do they brush their teeth? ____________ When? ____________

Do they use a hard/soft/medium brush? ____________ Do their gums bleed? ____________

Do they use dental floss? ______ How often? ____________ Toothpaste type: ____________

Does anyone help do the brushing or flossing? ____________

Do you see sores in the mouth or lips (canker sores/fever blisters, etc.)? ____________

____

Are you pleased with the dental appearance/function? Please explain: ____________

____

Are any teeth sensitive to sweet, cold, heat, pressure, chewing, etc.? ____________

____

Are there any problems eating, chewing or swallowing? ____________

____

Are there any dental appliances (retainers, spacers, etc.)? ____________

Does the child get "uptight" or extremely nervous about dental treatment? ____________

For any specific procedures? ____________

Please check the box if YES

Have they ever used nitrous oxide (laughing gas) for relaxation during dental care? .... ☐

Have they ever had intravenous sedation (twilight sleep) or oral tranquilizers? .... ☐

Have they had injuries to the face/teeth/jaws/neck ? .... ☐

Have they had orthodontic treatment (braces, retainers, splints)? .... ☐

Does the child complain that the jaw joints click, pop, or lock? .... ☐

Are their jaw muscles sore or stiff in the morning? .... ☐

Do they clench or grind their teeth during the day or night? .... ☐

Please continue on the inside

Please check the box if YES

Are there frequent headaches/earaches? ☐

Please describe: ____________________

Have they had root canal (endodontic) treatment? ☐

Do they have eye problems not correctable by glasses or hearing problems not correctable by hearing aids? ☐

Serious illnesses or operations: ____________________

____

CURRENT drugs or medications: ____________________

____

Drugs/medications/injections in the last MONTH? Please specify ____________________

____

Is the child taking any of the following? **Please check the box if YES**

Antibiotics	☐	Antihistamines	☐
Anticoagulants	☐	Aspirin type products	☐
Blood Pressure medications	☐	Insulin, other diabetes medications	☐
Steroids, cortisone	☐	Nitroglycerine	☐
Tranquilizers/antidepressants	☐	Hormones	☐
Digitalis, heart drugs	☐	Medications for “nerves”/emotions	☐
Vitamins	☐	Fluoride supplements	☐

Frequent medications/injections for allergy, weight, regularity, etc. Aspirins?

____

Are they ALLERGIC or have they had a reaction to any of the following: **(Check box if YES)**

Local anesthetics	☐	Aspirin	☐
Novocain/Lidocaine	☐	Iodine	☐
Penicillin	☐	Other antibiotics	☐
Sulfas	☐	Codeine/other narcotics	☐
Barbiturates	☐	Sedatives/sleeping-pills	☐

Other ____________________

Have they ever had any of the following: **Please check the box if YES**

Diabetes	☐	High or low blood pressure	☐
Arthritis	☐	Stroke or heart valve problems	☐
Glaucoma	☐	Thyroid problems	☐
Kidney/stomach problems/ulcers	☐	Nasal obstruction/sinus problems	☐
Rheumatic fever	☐	Tuberculosis/lived with TB patient	☐
Syphilis, AIDS, gonorrhea, herpes	☐	Hay fever/allergies/asthma	☐
Congenital (birth) defects	☐	Sickle cell anemia	☐
Hepatitis/liver disease/jaundice	☐	Hemophilia/bleeder disease	☐

“The more we know, the more we can help!”

Do they have heart/blood vessel disease (like coronary insufficiency, coronary occlusion, heart attack, arteriosclerosis, heart surgery, etc.) ☐

Do they have a pacemaker/implanted heart valve or graft? ☐

Have they had a kidney transplant or bone graft/implants/artificial joints? ☐

Have they had X-ray treatment for a tumor, growth, cancer? ☐

Have they had abnormal bleeding from surgery or dental treatment? ☐

Are they frequently sad, depressed, blue? ☐

Are there foods they cannot eat because they make them sick? ☐

Do they bruise more easily than most people? ☐

Do they have any blood disorder such as anemia? ☐

Have they ever required a blood transfusion? ☐

What were the circumstances? ____________________

Do they participate in sports? Which? ____________________ ☐

Do they get short of breath when lying down? ☐

Do they need more than 2 pillows to sleep comfortably? ☐

Do their ankles swell or do they get chest pains with exertion? ☐

Do they have to stop walking because of pain or pressure in the chest? ☐

Do they have fainting spells, fits, seizures or epilepsy? ☐

Are they thirsty much of the time? ☐

Do they frequently have to urinate more than six times a day? ☐

Do they have to get up more than one time a night to urinate? ☐

Do they have a persistent cough/cough up blood or sputum? ☐

Have they had any psychiatric or emotional problems? ☐

Do they wear contact lenses? ☐

Do they pass bloodstained urine? ☐

Are bowel movements ever bloody or tarry black? ☐

Are they often too warm or too cold where others are comfortable? ☐

Do they get chronic sores or boils on the skin? ☐

Do they get hives or a skin rash? ☐

How is the health of close relatives? (parents/brothers/sisters) ____________________

Have any close relatives passed away? (parents/brothers/sisters) ☐

Have they ever had: **(Check the box if YES)**

Tonsils/adenoids removed ☐ Measles ☐

Mumps ☐ Chicken pox ☐

Scarlet fever ☐ Strep throat ☐

Oral habits:

Fingers sucking ☐ Mouth breathing ☐

Pencil biting ☐ Speech problems ☐

Tongue thrust ☐ Tongue tie ☐

Is there any other condition/disease/dental or medical problem that we should know about?

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____

Signature of parent/guardian Dentist Date

If you are completing this history for another person, what is the relationship? ____________________