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 _____

Adult Dental and Medical History

This detailed health review will help us to get to know you better and to understand your needs, concerns and goals for your treatment. Please feel free to ask any of us to help you with questions that may arise while working on this evaluation.

-Dr. Ra and the entire staff-

Patient's Name: _____ Date: _____

Last dentist name/address: _____
Date of last dental visit: _____
What was completed: _____
Have you had many cavities? _____
Have you lost many teeth? _____
Where did you live before the age of 12? _____
Was the water fluoridated? _____
How often do you brush your teeth? _____
Do you use a hard, medium or soft toothbrush? _____
What type of toothpaste do you use? _____
Do you use dental floss and how often? _____
Are you sensitive to sweet, cold, heat or pressure? Y□ N□
Are you having any problems eating, chewing or swallowing? Y□ N□
Do you chew ice or hard kernels? Y□ N□
Do you get canker sores or fever blisters on or around your mouth? Y□ N□

Are you wearing any removable dental appliances? (Partials or Dentures) Y□ N□
If yes, when were they made? _____

Have you had any periodontal (gum) treatments? Y□ N□
Do your gums bleed while brushing or flossing? Y□ N□
Do you feel that you have breath problems? Y□ N□

Have you ever had endodontic (root canal) treatments? Y□ N□
How was the experience? _____

Have you had orthodontic (braces, retainers) treatment? Y□ N□
Do your jaw joints click, pop, or lock? Y□ N□
Are your jaw muscles sore or stiff when you wake up? Y□ N□
Do you clench or grind your teeth during the day or night? Y□ N□

Do you get "uptight" or extremely nervous about dental treatment? Y□ N□
Have you ever had medical/dental hypnosis? Y□ N□
Have you ever used nitrous oxide (laughing gas) during dental treatment? Y□ N□

Have you ever had intravenous sedation (twilight sleep) during dental treatment? Y□ N□

Oral Habits **(Check box if Yes)**

Finger Sucking	□	Mouth Breathing	□
Pencil Biting	□	Speech Problems	□
Tongue Thrust	□	Tongue Tie	□

Are you pleased with your dental function? Y□ N□
Are you pleased with your dental appearance (color, shape, etc)? Y□ N□
Please explain: _____

Adult Medical History

Physician name/address: _____
Date of last physical exam: _____
Are you under any treatment? _____
Please explain: _____

Are you taking any of the following medications? **(Check box if Yes)**

Antibiotics	☐	Diabetic Medications (Insulin, Diabenese)	☐
Anticoagulants/Blood Thinners (Coumadin)	☐	Birth Control Pills/Hormones	☐
Blood Pressure Medications (Atenolol)	☐	Aspirin or Ibuprofen (Motrin, Naproxen)	☐
Steroids, Cortisone	☐	Fluoride Supplements	☐
Tranquilizers (Valium, Diazepam)	☐	Narcotics (Codeine)	☐
Heart medications (Indural, Digitalis)	☐	Vitamins	☐
Antidepressants (Wellbutrin, Prozac)	☐	Antihismines (decongestants)	☐

Other: _____

Have you been prescribed any medications that you are not taking? _____
_____

Are you ALLERGIC or had any reaction to any of the following medications?

Local anesthetics	☐	Aspirin	☐
Penicillin or Amoxicillin	☐	Iodine	☐
Sulfas	☐	Codeine or other narcotics	☐
Barbiturates (Valium)	☐	Latex	☐

Other: _____

Have you ever had any of the following?

Mitral Valve Prolapse	☐	Diabetes/Kidney Disorders	☐
Arthritis	☐	Glaucoma	☐
Stomach Problems/Ulcers	☐	Rheumatic Fever	☐
Syphilis, Gonorrhea	☐	HIV/AIDS	☐
Hay Fever/Sinus/Allergies	☐	Asthma	☐
High Blood Pressure	☐	Hyperthyroid	☐
Low Blood Pressure	☐	Hypothyroid	☐
Hepatitis	☐	Tonsils/Adenoids Removed	☐
Liver Disease/Jaundice	☐	Measles	☐
Chicken Pox	☐	Strep Throat	☐
Scarlet Fever	☐	Congenital (birth) Defects	☐
Sickle Cell Anemia	☐	Hemophilia/Bleeder Disease	☐
Herpes Simplex (Mouth)	☐	Tuberculosis/live with TB patient	☐
Cholesterol Problems	☐	Nasal Obstructions	☐
Heart Murmur	☐	Anemia	☐

Other: _____

Do you have a pacemaker, implanted heart valve or graft? Y☐ N☐
Do you stop walking due to pain or pressure in the chest? Y☐ N☐
Do your ankles swell? Y☐ N☐
Do you have heart /blood vessel disease (Heart attack, murmur, angina or palpitations)? Y☐ N☐
Have you ever had heart surgery (bypass or angiogram)? Y☐ N☐
Have you ever had a stroke or TIA? Y☐ N☐
Have you ever been told to premedicate with an antibiotic? Y☐ N☐

Are there foods you cannot eat because they make you sick? Y☐ N☐
Do you have a history of ulcers or chronic stomach pain? Y☐ N☐
Do you have heartburn /acid reflux? Y☐ N

Do you have a persistent cough or cough up blood? Y☐ N☐
Do you need more than 2 pillows to sleep comfortably? Y☐ N☐
Do you snore? Y☐ N
Do you get short of breath while lying down? Y☐ N☐
Do you get thirsty a lot? Y☐ N☐
Do you frequently have to urinate more than 6 times a day or night? Y☐ N☐
Have you ever had a kidney transplant? Y☐ N☐
Have you had a bone graft or implants? Y☐ N☐
Have you had an artificial joint or hip replacement? Y☐ N☐

Have you ever had a blood transfusion? Y☐ N☐
What were the circumstances? _____
Do you bruise easily? Y☐ N☐
Do you pass blood-stained urine? Y☐ N☐
Are your bowel movements ever bloody or tarry black? Y☐ N☐
Have you had abnormal bleeding from surgery or dental treatment? Y☐ N☐
Have you ever been told that you could not donate blood? Y☐ N☐

Have you had x-ray treatment for a tumor, growth or cancer? Y☐ N☐
Do you get chronic sores or boils on the skin? Y☐ N☐
Do you get hives or skin rash? Y☐ N☐

Do you have eye problems not correctable with glasses? Y☐ N☐
Do you wear contact lenses? Y☐ N☐
Do you have hearing problems? Y☐ N☐
Do you wear hearing aids? Y☐ N☐
Do you have frequent headaches or migraines? Y☐ N☐
Do you get earaches or neck aches? Y☐ N☐

Are you frequently sad, depressed or blue? Y☐ N☐
Have you had any psychiatric or emotional problems? Y☐ N☐
Have you ever fainted? Y☐ N☐
Do you have seizures or epilepsy? Y☐ N☐

Do you drink alcoholic beverages daily? Y☐ N☐
Do you smoke or have you ever smoked? Y☐ N☐
How much?_____ For how long?_____
Do you use any recreational drugs? If so what _____ Y☐ N☐
Do you exercise regularly? _____ Y N

Are you too warm or too cold when others are comfortable? Y☐ N☐
How is the health of your close relatives? _____
Have any close relatives passed away? (Parents, Siblings, Children)_____

Females:
Are you pregnant? If yes, what month? _____
Are there/were there any pregnancy-related problems? _____
Did any babies weigh more than 10 pounds at birth? Y☐ N☐
Have you had any other birth or delivery problems? Y☐ N☐
Do you have any problems associated with menstrual periods? Y☐ N☐

I understand the importance of providing a truthful history to assist my doctor in providing the best possible care. I have had the opportunity to discuss my health history with my doctor.

Patient/Guarantor's signature: _____ Date _____
Relation to patient if not self_____
Doctor's signature _____ Date _____