true smiles DENTAL

PATIENT REGISTRATION FORM

Date: ____________

PATIENT INFORMATION

Name *(Last, First, M.I.)*: ____________ ☐ Male ☐ Female
Social Security #: ____________ **DOB:** ____________ **Age:** ____________
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor
Address: ____________ **City:** ____________ **State:** ______ **Zip:** ____________
Primary Phone #: ____________ **Secondary Phone #:** ____________
Email Address: ____________ **Whom may we thank for referring you?** ____________

INSURANCE INFORMATION

Name: ____________ **Relationship to Patient:** ____________ **DOB:** ____________
Address *(if different from patient's):* ____________
Employer: ____________ **Occupation:** ____________ **SSN or ID #:** ____________
Insurance Name: ____________ **Group #:** ____________ **Subscriber #:** ____________

MEDICAL HISTORY

Physician's Name: ____________ **Phone #:** ____________ **Date of Last Visit:** ____________
Are you currently having any conditions treated? ☐ Yes ☐ No If yes, please describe: ____________
Have you had any serious illnesses or surgeries? ☐ Yes ☐ No If yes, please describe: ____________
(WOMEN) Are you pregnant? ☐ Yes ☐ No How many weeks? ______ Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check if you have or have had any of the following:

☐ Anemia	☐ Chemical Dependency	☐ Fainting	☐ Kidney Disease	☐ Stroke
☐ Angina/Chest Pain	☐ Chemotherapy	☐ Glaucoma	☐ Liver Disease	☐ Swelling of Feet/Ankles
☐ Arthritis, Rheumatism	☐ Circulatory Problems	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Artificial Heart Valves	☐ Cortisone Treatments	☐ Heart Murmur	☐ Pacemaker (Heart)	☐ Tobacco Habit
☐ Artificial Joints	☐ Cough, Persistent	☐ Heart Problems	☐ Radiation Treatment	☐ Tonsillitis
☐ Asthma	☐ Cough up Blood	☐ Hemophilia	☐ Respiratory Disease	☐ Tuberculosis
☐ Back Problems	☐ Cold Sores/Fever Blisters	☐ Hepatitis	☐ Rheumatic Fever	☐ Ulcer
☐ Blood Disease	☐ Diabetes	☐ High Blood Pressure	☐ Scarlet Fever	☐ Venereal Disease
☐ Bruise Easily	☐ Emphysema	☐ HIV/AIDS	☐ Shortness of Breath	
☐ Cancer or Tumor	☐ Epilepsy or Seizures	☐ Jaw Pain	☐ Skin Rash	

☐ OTHER (Please explain or elaborate on above conditions):

____

MEDICATIONS: (List medications you are currently taking)

____

____

ALLERGIES:

☐ Aspirin ☐ Codeine or other narcotics ☐ Dental Anesthetics ☐ Penicillin ☐ Erythromycin
☐ Latex ☐ Iodine ☐ Barbiturates, sedatives ☐ Metals ☐ Other: ____________

Nearest relative not living with you:
Name: ____________ **Relationship to Patient:** ____________
Address: ____________ **Phone #:** ____________

DENTAL HISTORY

Reason for Today's Visit: ____________
Date of Last Dental Visit: ____________ **Reason for Visit:** ____________
Why did you leave your previous dentist? ____________
How can we accommodate you better during your dental visit? ____________
Check if you have problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Apprehension about dental treatment
☐ Bleeding, irritated, or tender gums	☐ Loose teeth or broken fillings	☐ Sores or growths in your mouth
☐ Clicking or popping jaw	☐ Pain or swelling	☐ Discolored teeth that bother you
☐ Food collection between teeth	☐ Sensitivity to cold, hot, sweets, or biting	☐ Unhappy with appearance of teeth

I understand that the above information is necessary to provide me with safe and efficient dental care. To the best of my knowledge, all of the preceding answers are true and correct. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize direct payment of dental benefits otherwise payable to me, directly to True Smiles Dental. **I understand that I am financially responsible for all charges whether or not paid by insurance and accept full responsibility for all charges not covered by insurance.**

____________ ____________
Signature of Patient or Guardian (Responsible Party) Date