

# Adult Registration Form

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Name \_\_\_\_\_ Called by \_\_\_\_\_ Birth date \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip Code \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip Code \_\_\_\_\_

Email address \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Marital Status \_\_\_\_\_ Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

If patient is a minor, who is legally responsible: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip Code \_\_\_\_\_

Whom may we thank you for referring you? \_\_\_\_\_

Do you have dental insurance \_\_\_\_\_ Name of Company \_\_\_\_\_ Insured Employer's Name \_\_\_\_\_

Name of Insured \_\_\_\_\_ Insured's Social Security No. \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

The following information is required for us to thoroughly diagnose any condition and give you personal attention. Please fill out the following completely. All information given will be regarded as confidential.

## MEDICAL HISTORY

Family Physician \_\_\_\_\_

Please circle "YES" or "NO," if "YES," please fill in details.

Yes No Do you have a current medical problem? Describe \_\_\_\_\_

Yes No Do you have heart trouble? What kind? \_\_\_\_\_

Yes No Do you have osteoporosis? How is it treated? \_\_\_\_\_

Yes No Do you have high or low blood pressure? Is it controlled? \_\_\_\_\_

Yes No Have you ever had diabetes? How is it controlled? \_\_\_\_\_

Yes No Do you frequently have headaches of any kind? How often? \_\_\_\_\_

Yes No Do you take tranquilizers or sedatives? How often? \_\_\_\_\_

Yes No Are you allergic to any medication? What? \_\_\_\_\_

Yes No Have you ever had tuberculosis? When? \_\_\_\_\_

Yes No Have you ever had infectious hepatitis? When? \_\_\_\_\_

Yes No Have you ever had a tumor or cancer? How was it treated? \_\_\_\_\_

Yes No Have you tested positive for HIV? \_\_\_\_\_

Yes No Do you take more than one alcoholic drink per day? \_\_\_\_\_

Yes No Do you use any tobacco products? How much a day? \_\_\_\_\_

Yes No Have you taken any medications by IV? For what? \_\_\_\_\_

Yes No Have you been diagnosed with sleep apnea? Do you use a C-PAP machine? \_\_\_\_\_

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Yes No Are you taking any medication? Please list: Taking \_\_\_\_\_ For \_\_\_\_\_

Taking \_\_\_\_\_ For \_\_\_\_\_ Taking \_\_\_\_\_ For \_\_\_\_\_

Circle if you have or have had a problem with any of the following: Asthma Ulcer Epilepsy injury to face Blood Disorders  
(For these, or any other medical problems, please describe and tell when problem occurred.)

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## DENTAL HISTORY

What is your immediate dental concern? \_\_\_\_\_

The type of treatment I would like is:

- CIRCLE ONE:
- A. Best modern dentistry has to offer.
  - B. Best but on a somewhat limited budget.
  - C. Best but finances are a major concern and limiting factor.
  - D. Best but just keep me out of pain. Fear is my major concern.
  - E. Best but please get me out of pain. I'll see you next time something hurts.

Please circle "YES" or "NO," if "YES," please fill in details.

Yes No Have you ever had orthodontic treatment (braces)? When? \_\_\_\_\_

Yes No Do you have any growths or swellings in your mouth? \_\_\_\_\_

Yes No Do your gums bleed when brushing your teeth? \_\_\_\_\_

Yes No Is any part of mouth sensitive to hot, cold, pressure or chewing? \_\_\_\_\_

Yes No Are you aware of your jaw clicking while eating or yawning? \_\_\_\_\_

Yes No Do you frequently wake up with a headache or a neck ache? \_\_\_\_\_

Yes No Do you feel you will eventually wear full dentures? \_\_\_\_\_

Yes No Are you nervous about dental treatment? \_\_\_\_\_

Yes No Have you ever had a partial or complete dentures? Year Made \_\_\_\_\_

Yes No Would you like whiter teeth? \_\_\_\_\_

Yes No Is there anything you don't like about the appearance of your teeth or the way you smile? \_\_\_\_\_

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FOR WOMEN

Yes No Are you pregnant? Expected delivery date \_\_\_\_\_

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, CONSENT TO THE PERFORMING OF THE DENTAL AND ORAL SURGERY PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE AND WILL ASSUME RESPONSIBILITIES FOR FEES ASSOCIATED WITH THOSE PROCEDURES.

Signature \_\_\_\_\_ Date \_\_\_\_\_