Dental Horizons
Guiding Generations to Healthy Smiles

Adult Patient Registration

Today's Date: _____

Last Name: _____ First Name: _____ MI _____

Marital Status: Single ❑ Married ❑ Divorced ❑ Widowed ❑

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____

Apt #: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ SS#: _____

Email: _____ Age: _____ Male ❑ Female ❑

Primary Insurance Policy Holder: _____

Last: _____ First: _____ MI: _____

Date of Birth: _____ Age: _____ SS #: _____

Employer: _____

Insurance Company: _____ Phone: _____

Address: _____

Member/Subscriber ID#: _____ Group#: _____

Secondary Insurance Policy Holder:

Last: _____ First: _____ MI: _____

Date of Birth: _____ Age: _____ SS #: _____

Employer: _____

Insurance Company: _____ Phone: _____

Address: _____

Member/Subscriber ID#: _____ Group#: _____

Emergency Contact Information: _____

Emergency Contact Name: _____ Phone: _____

How were you referred to this office?

❑ Friend or Family (Name): _____

❑ Community Event ❑ Yellow Pages ❑ Facebook ❑ Walk in ❑ Mailer

❑ Internet site: _____ ❑ Referred by Dr. _____

❑ Other _____

How will today's services be taken care of?

❑ Cash ❑ Check ❑ Credit Card (MC / Visa / Discover / American Express / Care Credit)

Dental History:

Have you ever had, or currently have, any of the following conditions?

Bleeding Gums	❑ yes	❑ no	Clench / Grind Teeth	❑ yes	❑ no
Tender or Swollen gums	❑ yes	❑ no	Unusual dental experiences	❑ yes	❑ no
Loose Teeth	❑ yes	❑ no	Orthodontic Treatment	❑ yes	❑ no
Sensitive Teeth	❑ yes	❑ no	Periodontal (gum) Treatment	❑ yes	❑ no
Any other sore areas	❑ yes	❑ no	Root Canal Treatment	❑ yes	❑ no
Any injury to the mouth	❑ yes	❑ no	Crown or Bridge Treatment	❑ yes	❑ no

Do you ever have clicking, popping, or discomfort in the jaw joints? ❑ yes ❑ no

Do you have headaches, earaches, or neck pains? ❑ yes ❑ no

Are you unhappy with the appearance of your teeth? ❑ yes ❑ no

Is there anything else about your dental history we should know?

_____

_____

_____

Do you have any questions or concerns?

_____

_____

What is the name of your medical doctor? _____

Are you currently under medical treatment? ❑ yes ❑ no

If yes, please explain :

_____

_____

Have you been hospitalized within the past three years? ❑ yes ❑ no

Why? _____

Do you have any allergies or adverse reactions to drugs? ❑ yes ❑ no

Please list: _____

Are you taking any medications, pills, drugs, or herbal supplements? ❑ yes ❑ no

Please list: _____

Have you ever taken Bisphosphonates, such as Fosamax, Actonel, Aredia, Boniva, or Zometa? ❑ yes ❑ no

Do you currently use any form of tobacco? ❑ yes ❑ no

What form? _____ How much? _____

Are you interested in quitting? ❑ yes ❑ no

Women (Please mark)

Are you: ❑ Pregnant ❑ Nursing ❑ On Hormone Therapy ❑ Using Birth Control ❑ N/A

Has a Physician ever informed you that you have or have had any of the following conditions?

(please check box)

Heart Trouble	❑ yes	❑ no	Ulcers	❑ yes	❑ no
Heart Murmur	❑ yes	❑ no	Acid Reflux	❑ yes	❑ no
Rheumatic Fever	❑ yes	❑ no	Osteoporosis	❑ yes	❑ no
Congenital Heart Defect	❑ yes	❑ no	Tuberculosis	❑ yes	❑ no
Artificial Heart Valve	❑ yes	❑ no	Bruise Easily	❑ yes	❑ no
Heart Pacemaker	❑ yes	❑ no	Sinus Trouble	❑ yes	❑ no
Heart Surgery	❑ yes	❑ no	Cancer	❑ yes	❑ no
History of bacterial endocarditis	❑ yes	❑ no	Kidney Trouble	❑ yes	❑ no
Chest Pain	❑ yes	❑ no	Liver Disease	❑ yes	❑ no
High Blood Pressure	❑ yes	❑ no	Hepatitis (any form)	❑ yes	❑ no
Low Blood Pressure	❑ yes	❑ no	Nervousness	❑ yes	❑ no
Blood Disease	❑ yes	❑ no	Psychiatric Care	❑ yes	❑ no

Anemia	❑ yes	❑ no	**AIDS / HIV**	❑ yes	❑ no
Bleeding Problems	❑ yes	❑ no	**STI** (sexually transmitted infection)	❑ yes	❑ no
Asthma	❑ yes	❑ no	**Arthritis / Gout**	❑ yes	❑ no
Shortness of Breath	❑ yes	❑ no	**Rheumatism**	❑ yes	❑ no
Emphysema	❑ yes	❑ no	**Frequent Headaches**	❑ yes	❑ no
Lung Disease	❑ yes	❑ no	**Auto-immune Disorder**	❑ yes	❑ no
Fainting or Dizziness	❑ yes	❑ no	**Thyroid Disorder**	❑ yes	❑ no
Stroke	❑ yes	❑ no	**Seizures**	❑ yes	❑ no
Diabetes	❑ yes	❑ no	**Tobacco Use**	❑ yes	❑ no
Artificial Joints/Hips	❑ yes	❑ no	**Drug Use / Addiction**	❑ yes	❑ no
			Sleep Apnea	❑ yes	❑ no

Any other serious illness or health problem not mentioned above? ❑ yes ❑ no

Please describe:

_____

_____

Do you wish to speak to the doctor privately about any problem? _____

I certify that the above information is complete and accurate.

Signature of Patient, Parent or Guardian _____ **Date:** _____