PATIENT REGISTRATION FORM

Today's Date: ______________Whom May we thank for your referral: ___________________________

Patient Information

Last Name: ____________________________ First Name: _______________________ M.I ________

Birth Date: ___/____/____ Social Security number: _________-_________-_________

Sex: ___________ Marital Status: _______________ Name of spouse/Parent: _____________________

Address: ____ Apt# ___________________

City: ____________________ State: __________ Zip Code: ______________

Home Phone #: ________________________________Cell Phone #: ________________________

Email: ____

Best way to reach you: ____

Patient or Parent's employer: ____

Spouse's Information:

Last Name: ___________________________ First Name: ______________________________________

Spouse Phone #: Cell: _____________________________________ Home: ________________________

Spouse Email: _________________________________ DOB: ____/___/____

Dental Insurance

Name of Subscriber: _________________________________ Subscriber ID #______________________

Insurance Company: ____ Group # ____________________

Insurance Company Billing Address and Phone Number:

____

Southern Smiles
Dentistry

Dental History

Patient Name (please print): ____________________

(Please check any of the following that apply to you)

- ❑ Sensitivity (hot, cold, sweets, pressure)
- ❑ Discomfort when chewing
- ❑ Headaches, earaches, neck pain
- ❑ Jaw joint pain
- ❑ Teeth or fillings breaking
- ❑ Bad breath/bad taste in mouth
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, chipped or shifting your mouth
- ❑ Grinding or clenching teeth

What would you like to do to improve your smile?

- ❑ Whiten
- ❑ Straighten
- ❑ Close spaces
- ❑ Replace silver fillings with tooth colored fillings
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns that don't match other teeth

Do you have or have you ever had any of the following?

❑ Dentures ❑ Partial Dentures
❑ Braces ❑ Periodontal (gum) treatments

How long has it been since your last cleaning?

❑ Less than 1 yr ❑ 1-2 yrs ❑ 3-5 yrs ❑ over 5 yrs

What is most important about your visit today? ____________________

____________________ Name of previous dentist
____________________ Phone number
____________________ City & State

Why did you leave your previous dentist? ____________________

____

Previous dental experiences: ____________________

On a scale of 1 to 10 with 10 being the highest:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Sleep History

Have you ever had a sleep study or do you currently use a CPAP? ❑Yes ❑No
Does your partner say that you snore? ❑Yes ❑No
Do you take frequent naps during the day, or often feel tired? ❑Yes ❑No
Other: ____________________

Medical History

Have you been under the care of a medical doctor during the past two years? ❑Yes ❑No
If yes, for what? ____________________

Physician's name: ____________________ Last visit to Physician: ____________________

Do you have high blood pressure? ❑Yes ❑No What is your normal blood pressure? ____________________

Emergency Contact: ____________________ **Phone Number:** ____________________

Are you allergic or have you had a reaction to the following:

Local Anesthetic ❑Yes ❑No
Penicillin or other antibiotics ❑Yes ❑No
Aspirin, Ibuprofen or Tylenol ❑Yes ❑No
Codeine, Valium or other sedatives ❑Yes ❑No
Latex or metals ❑Yes ❑No

Updates:
Initials__________ Date __________
Initials__________ Date __________
Initials__________ Date __________
Initials__________ Date __________

Patient Signature: ____________________ **Date:** __________
Doctor Signature: ____________________ **Date:** __________