THE DENTAL ER

1601 W JACKSON ST – SUITE 108 – MACOMB, IL 61455 – (309)421-0490

PATIENT REGISTRATION

Today's Date: _____

Patient Name: _____ Sex: M F Birthdate: _____ Age: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Please Circle One: Single Married Separated Divorced Widowed Patient SS#: _____

Home Phone#: _____ Cell Phone #: _____ E-mail Address: _____

Patient Employer: _____ Work Phone#: _____ Years of Employment: _____

How would you prefer To be reached: *(Please Circle One)* Home Phone Cell Phone Work Phone E-Mail Other: _____

Driver's License #: _____ How Did You Hear About Our Office? _____

Spouse/Partner (or guardian if patient is a minor)

Name: _____ Sex: M F Birthdate: _____ Age: _____

Relationship To Patient: _____ Home Phone#: _____ Cell Phone#: _____ Work Phone# _____

Dental Insurance Information

Primary Insurance

Policy Holder: _____ Birthdate: _____
Relationship to Patient: _____ Phone #: _____
Employer: _____ Phone #: _____
Group Name: _____ Group #: _____
Policy Holder ID #: _____
Policy Holder SS#: _____
Insurance Company: _____
Claims Mailing Address: _____
_____
Provider Customer Service Phone # _____

Secondary Insurance

Policy Holder: _____ Birthdate: _____
Relationship to Patient: _____ Phone #: _____
Employer: _____ Phone #: _____
Group Name: _____ Group #: _____
Policy Holder ID #: _____
Policy Holder SS#: _____
Insurance Company: _____
Claims Mailing Address: _____
_____
Provider Customer Service Phone # _____

Dental Health History

	Yes	No
Do you wear dentures?	☐	☐
Are you apprehensive about dental treatment?	☐	☐
Do you gag easily?	☐	☐
Does food get caught between your teeth?	☐	☐
Do you have difficulty chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed While brushing/flossing?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow healing sores in or around your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you notice pain or sensitivity to your teeth with any of the following:		
Hot foods or liquids?	☐	☐
Cold food or liquids?	☐	☐
Sweets?	☐	☐
Sours?	☐	☐
Are you satisfied with the appearance of your teeth?	☐	☐
Have you ever had any of the following:		
Orthodontics/Braces?	☐	☐
Oral Surgery?	☐	☐
Worn a splint or other oral appliance?	☐	☐
TMJ Treatment?	☐	☐

	Yes	No
How often do you brush your teeth? _____		
How often do you floss? _____		
Does your jaw make noise so that it bothers you or others? _____	☐	☐
Do you clench or grind your teeth frequently? _____	☐	☐
Do your jaws ever feel tired or uncomfortable? _____	☐	☐
Does your jaw get stuck so that you can't open freely? _____	☐	☐
Have you had a blow to the jaw (trauma)? _____	☐	☐
Do you have earaches or pain in front of the ears? _____	☐	☐
Do you have any jaw symptoms or headaches upon awakening In the morning? _____	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (Pain relievers, muscle relaxants, antidepressants?)	☐	☐
Have you been diagnosed with temporomandibular (jaw) disorder (TMJ)?	☐	☐
Do you have pain in the face, cheeks, jaw, throat or temples? _____	☐	☐
Do you have difficulty upon opening your mouth? _____	☐	☐
Are you aware of an uncomfortable bite? _____	☐	☐

Medical Health History

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

	Yes	No
Heart Problems		
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Bruise easily	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever required a blood transfusion?	☐	☐
Required blood thinning medication	☐	☐
Allergy Problems?	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Strokes(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedication required by physician	☐	☐
If yes, reason for pre-med		
Cancer/Tumor	☐	☐
Chemotherapy	☐	☐
Radiation	☐	☐
Bisphonsphonate treatment or medications containing bisphosphonates	☐	☐

Are you allergic, or have you reacted adversely, to any of the following?

(if you answer yes to any of the following please specify)	Yes	No
Local anesthetics ("Novocain")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbituates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dental dam	☐	☐
Other		

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
Do you smoke?	☐	☐
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐

Do you have any disease, condition, or problem not listed previously That you feel we should know about? If so, please describe _____

Please list all medications you have taken in the last 12 months:

_____

_____

_____

_____

_____

_____

_____

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants/blood thinner (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐

Women	Yes	No
Are you taking contraceptives or Other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date:		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms?		

Notes : _____

_____

_____

Patient/Parent Signature: _____