Dental Office
Registration Form

Who referred you to this office? _____ Email Address _____

Name _____ Date of Birth _____ Marital Status _____

Social Security No. _____ Home Phone _____ Cell Phone _____ Name of Spouse _____

Mailing Address _____ City _____ State _____ Zip Code _____

Employment Address _____ City _____ State _____ Phone No. _____

Dental Insurance (circle one) Yes No Coverage (circle one) Self Spouse Both Parent

Insurance Co. Name _____ Complete Address to Send Form to _____

Whose Name is Coverage Under _____ Date of Birth _____ Certificate/Subscriber # _____

Employer (Company) Name _____ Address _____ City/State _____

Name and Address of Previous Dentist _____

Date _____ Your Signature (Parent's if Patient is a Minor) _____

(See Medical Questionnaire on Back)

Are you being treated for any condition by a physician now? ☐ Yes ☐ No

If yes, what is the condition? _____

Doctor's Name and Address _____

Are you taking any medicine or drugs at the present time? ☐ Yes ☐ No

If yes, please name _____

Have you been hospitalized in the past five years? ☐ Yes ☐ No

If yes, for what? _____

Are you allergic to penicillin, codeine or any other drug? ☐ Yes ☐ No

If yes, please name _____

Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No

Circle any of the following which you may have had:

Rheumatic Fever	Heart Murmur	Heart Attack	Tuberculosis
High Blood Pressure	Hepatitis	Jaundice	Epilepsy
Asthma	Diabetes	Stomach Ulcers	Kidney Trouble
Anemia	Tumors	Cancer	Herpes
AIDS	VD		

(Woman) Are you Pregnant? ☐ Yes ☐ No

If you have any disease, condition or problem not listed above that you think we should know about please explain: _____