

Patient Information

Patient's Name _____

Date _____

How do you prefer to be addressed? _____

Sex: M F

Street _____

Birth Date _____

City, State, Zip _____

Marital Status _____

Home Phone _____

Social Security# _____

Work Phone _____

Your General Dentist _____

Referred by _____

Dental Insurance Information:

Whose name is your insurance under? _____
(Name of Principal Insured)

Dental Insurance Carrier _____

Insurance Group # _____

Relationship to Patient _____

Employer's Name _____

Social Security # of Principal Insured _____

Employer's Address _____

Birth Date of Principal Insured _____

If Covered Under a Second Dental Insurance Plan:

Whose name is your insurance under? _____
(Name of Principal Insured)

Dental Insurance Carrier _____

Insurance Group # _____

Relationship to Patient _____

Employer's Name _____

Social Security # of Principal Insured _____

Employer's Address _____

Birth Date of Principal Insured _____

Account Information

Person Responsible For the Account _____

Relationship to Patient _____

I understand that the information on the Registration, Medical History and Dental History forms is necessary to provide dental care in a safe and efficient manner. I have answered the questions to the best of my knowledge. Should further information be needed, the staff of Progressive Periodontics, P.C., has permission to ask your respective health care provider(s) to release such information. I will notify this office of any change in my health or medications.

Signed: _____

Date _____

Registration



Patient's Name _____ Date _____

What is the reason for your visit? _____

Answers to the following are for our records and are confidential.

1. Have you been under the care of a medical doctor in the past two years? Yes No

If yes, for what? _____

Physician's Name _____ Phone _____

When was your last visit to your Physician? _____

2. Have you taken any medication or drugs in the past two years? Yes No

Are you taking any medications or drugs now? Yes No

If yes, please list prescription and non-prescription (vitamins, supplements, etc.) medications on Medication Log on page 6.

3. Are you aware of having any adverse reactions (allergies) to medications? Yes No

If yes, please list _____

4. Have you had or do you have any of the following? (Please complete both columns.)

Substance Abuse Problem	Yes No	Epilepsy	Yes No
Heart Disease	Yes No	Seizures	Yes No
High Blood Pressure	Yes No	A.I.D.S.	Yes No
Heart Murmur	Yes No	H.I.V. Positive	Yes No
Mitral Valve Prolapse	Yes No	Liver Disease	Yes No
Bleeding Problems	Yes No	Psychiatric Care	Yes No
Blood Transfusion	Yes No	Stroke	Yes No
Radiation Therapy	Yes No	Ulcers	Yes No
Chemotherapy	Yes No	Diabetes	Yes No
Venereal Disease	Yes No	Tuberculosis	Yes No
Hepatitis	Yes No	Cortisone	Yes No
Artificial Joints	Yes No		

5. Have you been told you need antibiotics prior to dental treatment? Yes No

6. Do you use more than two pillows to sleep? Yes No

7. Have you lost or gained more than ten (10) pounds in the last year? Yes No

8. Do you have a disease or condition not listed? Yes No

If yes, please list: _____

9. Women: Are you pregnant? Yes No

Nursing? Yes No

Taking birth control pills or using a birth control patch? Yes No

Medical History

Patient's Name _____ Date _____

Answers to the following are for our records and are confidential.

1. Do you have dental pain now? Yes No
2. When was your last dental visit? _____
What was done at that appointment? _____
3. Are your teeth sensitive to: hot or cold? Yes No
Sweets? Yes No
Biting or chewing? Yes No
Have you noticed any bad breath or bad tastes? Yes No
Do your gums ever bleed or hurt? Yes No
Have your parents lost any teeth or had gum disease? Yes No
Do you have any family history of diabetes? Yes No
Have you noticed any loose teeth or a change in your bite? Yes No
Does food tend to get caught between your teeth? Yes No
Do You: Clench or grind your teeth while awake or asleep? Yes No
Breathe through your mouth while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No
Do you smoke cigarettes? Yes No
If yes, how many per day do you smoke? _____
How many years have you smoked? _____
Are you interested in quitting? Yes No
Have you ever smoked cigarettes? Yes No
How long has it been since you quit? _____
How much did you smoke? _____
How long did you smoke? _____
Have you experienced clicking or popping in your jaws? Yes No
Headaches, neck or shoulder pain? Yes No
4. We are interested in your feelings about the following:
What do you think about losing your teeth? _____
What would you change about your smile or bite, if you could? _____
What is your biggest concern about having any dental treatment? _____

Dental History

