Renwick
family dentistry practice

"Dental Care You Can Trust"

# PATIENT REGISTRATION

Date _____

## PATIENT INFORMATION

**NAME** _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell # _____
Employer _____
Work Phone _____ Ext. _____
Social Security # _____ DOB _____
Drivers License # _____
Martial Status □Single □Married □Child Sex: □M □F

## POLICY HOLDER INFORMATION

**NAME** _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell # _____
Employer _____
Work Phone _____ Ext. _____
Social Security # _____ DOB _____
Dental Insurance _____
Insurance Company Phone (_____)_____

## MEDICAL HISTORY

Do you have any of the following:

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ___ | ___ | Any Heart Problems | ___ | ___ | Hepatitis A (infectious) | ___ | ___ | Glaucoma |
| ___ | ___ | Abnormal Blood Pressure | ___ | ___ | Hepatitis B or C | ___ | ___ | Blood Transfusion |
| ___ | ___ | Stroke | ___ | ___ | Latex Allergy | ___ | ___ | Tested positive for AIDS/HIV |
| ___ | ___ | Circulatory Problems | ___ | ___ | Malignancies | ___ | ___ | Venereal Disease |
| ___ | ___ | Excessive Bleeding | ___ | ___ | Fainting tendency | | | Specify _____ |
| ___ | ___ | Anemia | ___ | ___ | Epilepsy | ___ | ___ | Sinus Problems |
| ___ | ___ | Arthritis | ___ | ___ | Thyroid Disease | ___ | ___ | Tuberculosis |
| ___ | ___ | Respiratory Problems | ___ | ___ | Diabetes | ___ | ___ | Are you a nursing mother |
| | | (Asthma, Emphysema, etc.) | ___ | ___ | Unfavorable reaction to | ___ | ___ | Are You Pregnant |
| ___ | ___ | Takes Aspirin ***Daily*** | | | dental anesthetic | | | Due Date _____ |

Other _____

Do you have a history of ***(check "Y" or "N" where applicable)***: rheumatic fever □Y □ N, heart murmur □Y □ N, artificial valve or joint □Y □ N which now requires antibiotic pre-medication?

Are you allergic to any drugs? □Y □ N If YES, please list _____

Are you currently taking any medications? □Y □ N If YES, please list _____

Are there any other medical conditions of which I should be made aware? _____

Physician's Name & Phone # _____ Date of Last Physical Exam _____

Preferred Pharmacy & Phone # _____

Are you presently under the care of a physician: □Y □ N If YES, for what? _____

Have you ever been hospitalized? □Y □ N If YES, for what? _____

***Continued on back*** ☛

## DENTAL HISTORY

Are you currently experiencing a toothache or any other pain in your head or neck? If so, please describe: _____

_____

Date of your last dental exam? _____ Date of last Dental X-Rays _____

Date of your last dental cleaning? _____

***Have you ever had periodontal (gum) treatment (deep scaling or deep cleaning)?*** □Y □ N If YES, please list the dates of your last periodontal maintenance: _____

***If patient is under the age of 19, please provide the following information:***

Date of last application of fluoride: _____ Date of last application of sealants: _____

What would you change about your mouth or teeth if you could? _____

Do you have a history of:

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ____ | ____ | Gum Disease | ____ | ____ | Halitosis (Bad Breath) | ____ | ____ | Grinding Teeth (BRUXISM) |
| ____ | ____ | Abscesses | ____ | ____ | Sensitivities | ____ | ____ | Clicking or Popping TMJ |
| ____ | ____ | Sores (Ulcers) | ____ | ____ | Cold Sores/Fever Blisters | ____ | ____ | Pain in Jaw Joint |

Are there any other conditions or experiences of which I should be made aware? _____

Person to contact outside of immediate family in case of emergency:

Name _____ Phone # _____ Alternate # _____

Address _____ _____ _____ _____
Street City State Zip

## REFERRAL SOURCE

□ Family Member □ Yellow Pages □ Sign □ Mail □ Other (Specify) _____

***All information given is strictly confidential and will not be released to anyone without written consent.***

***The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Renwick Family Dentistry.***

_____ _____ _____

Signature (Patient, Parent or Guardian) Doctor's Signature Date

**** The following information must be provided before services are rendered:***

Patient's ⇨
- Social Security Number
- Date of Birth
- Driver's License Card

Policy Holder's ⇨
- Social Security Number
- Date of Birth
- Employer's Name
- Dental Insurance Name & Group Number