Advanced Dental Arts of South Brunswick

Patient Registration Form

Patient Information

Name:_____ Salutation:_____
Address:_____City_____State:_____ZipCode:_____
Phone # Home: _____Cell:_____ Work:_____
Email Address_____
The best time to contact me is: AM/PM The best contact number is my: Home/Work/Cell
Sex: Male/Female Date of Birth: _____ Social Security Number:_____
Circle Appropriate: Minor/Single/Married/Widowed/Separated/Divorced
If Student, Name of School:_____City/State:_____PT/FT?
Employer_____ Occupation: _____
Spouse or Parent's Name_____

Contact Person in Case of Emergency_____Relation_____
Home#_____ Cell#_____

Responsible Party

Relationship to Patient: Self/Spouse/Parent/Other
Name:_____Relationship to Patient:_____
Address:_____ City:_____ State_____
Zip Code:_____ Phone: _____
Employer_____ Occupation: _____
Work Phone:_____ SS#_____

Insurance Information

Name of Insured:_____ DOB_____ Relationship to Patient _____
SSN:_____ Name of Employer:_____
Address of Employer_____
City:_____ State:_____ Zip:_____ Work#:_____
Insurance Company_____
Group #_____ Member ID#_____
Ins. Co Address_____ Insu. Co Number_____

Whom may we thank for referring you? (Please be specific)
_____

Dental History

Why have you come to the dentist today? _____
Are you currently in pain? _____
Have you ever had a serious/difficult problem associated with any previous dental work? _____
Do you or have you ever had pain/discomfort in your jaw (TMJ)? Yes_____ No_____

Your current dental health is? Good_____ Fair_____ Poor_____
Do you like your smile? Yes _____ No_____
Do your gums ever bleed? Yes _____ No_____
How many times a week do you floss? _____
How many times a day do you brush? _____ Type of bristles? Hard___ Med____ Soft___
Last Dental visit date: _____ Last Dental x-rays: _____
Are you interested in replacing any missing teeth? Yes _____ No_____
Do you presently wear any removable bridges or dentures? Yes _____ No_____
Are you interested in doing away with your removable dentures? Yes _____ No____

Medical History
Your current physical health is Good_____ Fair_____ Poor_____
Are you currently under the care of a physician? Yes _____ No_____
Please explain if yes: _____
Are you taking any prescription/ OTC drugs? Yes _____ No_____
Please list each one or provide copy of list : _____
_____

Have you ever had any of the following diseases or medical problems?

Y N Heart Attack	**Y N** Congenital Heart Defect/ Artificial Valve
Y N Heart Murmur	**Y N** High/ Low blood pressure
Y N Heart Surgery/Pacemaker	**Y N** Anemia
Y N Mitral Valve Prolapse	**Y N** Blood transfusion
Y N Psychiatric Problems	**Y N** Hepatitis A B C
Y N Cancer/Chemotherapy/Radiation	**Y N** Hemophilia/ Abnormal Bleeding
Y N Shingles	**Y N** Venereal Disease
Y N Rheumatic Fever	**Y N** HIV+/AIDS
Y N Kidney Problems	**Y N** Liver Problems
Y N Tuberculosis (TB)	**Y N** Asthma/ Difficulty Breathing
Y N Sinus Problems	**Y N** Arthritis
Y N Epilepsy/Seizures/ Fainting Spells	**Y N** Diabetes
Y N Osteoporosis	**Y N** Drug/ Alcohol Abuse
Y N Severe/Frequent Headaches	**Y N** Ulcers/Colitis
Y N Hospitalized for any reason	**Y N** Smoking

Please list any medical condition(s) that you have ever had: _____
Are you allergic to any of the following drugs?
Y N Penicillin **Y N** Dental Anesthetics **Y N** Aspirin **Y N** Codeine
Other_____

For Women : Are you taking birth control pills? **Y N**
Are you pregnant? **Y N**
Are you nursing? **Y N**

Patient Signature: _____
Date: _____

I understand that the information that I provided today is correct to the best of my knowledge. I authorize my dentist to make photos, x-rays, or any other visual aids of my treatment to be used for the advancement of dentistry in any manner my dentist deems appropriate.

Patient Signature: _____

Date: _____