# Mt. Pleasant Family Dental
# Registration Form

PATIENTS NAME: _____ LAST NAME: _____
MIDDLE INITIAL: _____ SEX: MALE/FEMALE BIRTHDAY: _____ AGE: _____

SOC. SEC # _____ TODAY'S DATE: _____

If Patient is a Minor, give Parent's or Guardian's Name: _____

Reason for this Visit: _____

MAILING ADRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ HOW LONG: _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

WORK PHONE: _____ E-MAIL: _____

EMPLOYER: _____ OCCUPATION: _____

## EMERGENCY INFORMATION: FRIEND OR FAMILY NOT LIVING WITH YOU.

NAME: _____ RELATIONSHIP: _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

## DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)

INSURED'S NAME: _____ INSURANCE CO. _____

INSURANCED'S EMPLOYER: _____ INSURED'S SOC. SEC. # _____

INSURANCE ID # _____ GROUP # _____

## DENTAL INSURANCE INFORMATION (SECONDARY CARRIER)

INSURED'S NAME: _____ INSURANCE CO. _____

INSURANCED'S EMPLOYER: _____ INSURED'S SOC. SEC.# _____

INSURANCE ID # _____ GROUP # _____

## Let Us Know How You Heard About Us.

_____

# Mt. Pleasant Family Dental

## Dental History

Patient Name: _____ Date: _____

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|---|
| Last COMPLETE Dental Exam, Date: |
| Are you having any PROBLEMS now? |
| If yes, please explain: |
| Do you wear Partial or Complete DENTURES? |
| Are you APPREHENSIVE about dental treatment? |
| Have you had any PERIODONTAL (GUM) treatments? |
| Do your gums BLEED, or feel TENDER or IRRITATED? |
| Are your teeth SENSITIVE to HOT, COLD, SWEETS or PRESSURE? |
| Are you UNHAPPY with the APPEARANCE of your teeth? |
| Do experience any GRINDNG or CLENCHING? |
| Do you have HEADACHES, EARACHES, or NECK PAINS? |
| Have you worn BRACES on your teeth (ORTHODONTICS)? |
| Would you like your smile to LOOK BETTER or DIFFERENT? |
| Do you REGULARLY use DENTAL FLOSS? |
| Name of Previous Dentist: |
| City: State: Phone: |

# Mt. Pleasant Family Dental

## Medical History

- AIDS / HIV Positive
- Anaphylaxis
- Anemia
- Arthritis (Rheumatism)
- Artificial Joints
- Artificial Heart Valves
- Asthma
- Atopic (Allergy Prone)
- Back Problems
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Circulatory Problems
- Cortisone Treatment
- Cough (Persistent)
- Cough Up Blood
- Diabetes
- Epilepsy
- Fainting
- Food Allergies
- Glaucoma
- Headaches
- Heart Murmur
- Heart Problems
- Hemophilia (Abnormal Bleeding)
- Herpes
- Hepatitis
- High Blood Pressure
- Jaw Pain
- Kidney Disease or Malfunction
- Liver Disease
- Material Allergies (Latex, Wool, Metal, Chemicals
- Mitral Valve Prolapse
- Nervous Problems
- Pacemaker/Heart Surgery
- Psychiatric Care
- Rapid Weight Gain / Loss
- Radiation Treatment
- Respiratory Disease
- Rheumatic / Scarlet Fever
- Shingles
- Shortness of Breath
- Skin Rash
- Spina Bifida
- Stroke
- Surgical Implant
- Swelling of Feet or Ankles
- Thyroid Disease or Malfunction
- Tobacco Habit
- Tonsillitis
- Tuberculosis
- Ulcer / Colitis
- Venereal Disease

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

- Aspirin
- Local Anesthetic
- Erythromycin
- Latex (Balloons, Gloves, Etc.)
- Nitrous Oxide
- Codeine
- Penicillin

Is there any other Medical or Dental information that you feel I should know about?

Are you aware of being allergic to any other medications or substances?
Yes / No
If yes, please list:

Have you ever taken Fen-phen / Redux?
Yes / No

Are you under a PHYSICIAN'S CARE now? _____

What MEDICATIONS are you currently taking? _____

Are you currently PREGNANT? _____Do you use cigars / cigarettes, pipe or chewing tobacco? _____

Family Physician: _____Phone: _____

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____