PATIENT REGISTRATION

TODAY'S DATE____________

Patient's Name	**Birth date**		**Age**	**Sex:** M F
Home Address	**City**	**State**	**Zip**	
Home Phone #	***Please Circle One:*** Single, Married, Separated, Widow		**Your Social Security Number**	
Your Employer	**Occupation**		**Work Phone #**	
Are you a full time student? ☐Yes ☐ No	*If patient is minor we need Mother & Father's Names & Birth date*			
Person responsible for account:	**YOUR Driver's License Number:**			
Name of spouse (or parent if minor)	**YOUR E-mail address**		**YOUR cell phone #**	
Spouse's (or parent's) employer	**Spouse's Soc. Sec. #**		**Work phone #**	

EMERGENCY INFORMATION

Name, Address, & Telephone of A relative not living with you:
How did you hear about our office?
Reason for this visit?

DENTAL INSURANCE INFORMATION (Primary Carrier)			**If you have a dual insurance coverage, complete this for the second coverage (this office bills primary ins only)**		
Insured's name	**DOB**	**SS#**	Insured's name	DOB	SS#
Insured's employer			Insured's employer		
Insurance Co			Insurance Co		
Insurance Co Address			Insurance Co Address		
Phone #			Phone #		
Group #	**Policy #**		Group #		Local #

Is there anything other medical or dental history we should know?		
Patient Signature (or parent of child)	Date	Doctor's Signature

DENTAL HISTORY

Please check any of the following problems that apply to you:
- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifted teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?
- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Gum treatments

Please share the following dates:

Your last cleaning ______/______

Your last oral cancer screening ______/______

Your last complete x-rays ______/______

Name of Previous Dentist:

____

City: ____________________ State: __________________

Phone number: ____________________________________

What is the most important thing to you about your future smile and dental health?

____

If you could whiten your teeth for a cost anyone could afford, would you do it?

____

Do you smoke or use chewing tobacco?
How much? For how long?

____

If you could change your smile, you would:
- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1 -10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

____

____

What is the most important thing to you about your dental visit today?

____

____

MEDICAL HISTORY

Please check any of the following that apply to you:

☐ Allergies (Seasonal)	☐ Excessive Bleeding	☐ Nervousness/Depression	☐ Ulcers
☐ Anemia	☐ Glaucoma	☐ Pacemaker	☐ OTHER (please list):
☐ Artificial Heart Valve	☐ Heart Conditions	☐ Phen Fen (1 month +)	____________________
☐ Artificial Joints	☐ Heart Murmur	☐ Radiation (head/neck)	____________________
☐ Asthma	☐ Hepatitis A	☐ Respiratory Problems	____________________
☐ Blood Disease	☐ Hepatitis B	☐ Rheumatic Fever	____________________
☐ Bruise Easily	☐ Hepatitis C	☐ Rheumatism	____________________
☐ Cancer	☐ High Blood Pressure	☐ Scarlet Fever	____________________
☐ Chemotherapy	☐ HIV/AIDS	☐ Seizures	**For WOMEN Only**
☐ Diabetes	☐ Jaundice	☐ Stomach Problems	❑ Birth Control Pills
☐ Dizziness/Fainting	☐ Kidney Disease	☐ Stroke	❑ Breast-feeding
☐ Drug Addiction	☐ Liver Disease	☐ Thyroid Disease	❑ Pregnant
☐ Emphysema	☐ Mitral Valve Prolapse	☐ Tuberculosis	1-3 mos,3-6 mos,6-9mos,

Do you have an allergy to any of the following?

☐ Aspirin	☐ Codeine	**What medications**
☐ Erythromycin	☐ Other:	**are you currently**
☐ Latex	________	**taking?**
☐ Local Anesthetic	________	______________
☐ Nitrous Oxide	________	______________
☐ Penicillin	________	______________

Are you under a physician's care? For what?

____

____

Family Physician	**Phone Number**
____________________	____________________

THOMAS W. NABORS, DDS

cosmetic + general dentistry

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