Patient Registration

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CANTON PROFESSIONAL PARK
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(734) 451-0995

E-mail ____________________ Today's Date __________

Name: ______________________________ Phone: (H) ____________________

Address: ______________________________ (W) ____________________

______________________________ (C) ____________________

Employed by: ______________________________ Birthdate: ____________________

Address: ______________________________ Social security #: ____________________

______________________________ Dental Insurance: ____________________

ID Number: ____________________

Spouse's name: ______________________________ Social Security # ____________________

Employed by: ______________________________ Dental insurance ____________________

Cell Phone: ______________________________ ID number: ____________________

Work Phone: ______________________________ Group number:: ____________________

Birthdate: ______________________________ ____________________

Name of a friend, neighbor or relative in case of emergency: ______________________________

Address: ______________________________ Phone: ____________________

Who will pay this account? (Whose name will appear on the billing statement?): ____________________

Who may we thank for referring you to our office? ______________________________

Dental Information *For the following questions, please mark (X) your responses to the following questions*

Question	Yes	No	DK
Do your gums bleed when you brush or floss	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associates with previous dental treatment?	☐	☐	☐
Is your home water's supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY

Question	Yes	No	DK
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

What is the reason for your dental visit today?

____

How do you feel about your smile?

____

Is there anything else we should know about your teeth or dental condition?

____

Question	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you had serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam: ____________________

What was done at that time?

____

Date of last dental x-rays

____

Medical History

Physician's name________________ Date of Last Physical Exam: ____________

Address: ________________ Do You Smoke? ____________

Phone: ________________ Drink Alcoholic Beverages? ____________

Is there any reason (medical or otherwise) not to treat you today? ____________

Do you have or have you ever been treated for:

	Yes	No
Heart Disease	☐	☐
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Abnormal Blood Pressure	☐	☐
Glaucoma	☐	☐
Artificial Heart Valve	☐	☐
Congenital Heart Disease	☐	☐
Anemia	☐	☐
Diabetes Type I or II (Circle)	☐	☐
Epilepsy	☐	☐
Arthritis	☐	☐
Autoimmune Diseases	☐	☐

	Yes	No
Tuberculosis	☐	☐
Lung Disease	☐	☐
Asthma	☐	☐
COPD (Emphysema)	☐	☐
Hay Fever	☐	☐
Sinus Problems	☐	☐
Cough	☐	☐
Jaundice or Hepatitis	☐	☐
GERD	☐	☐
Ulcers	☐	☐
HIV-AIDS	☐	☐

Have you had any joint replacements? ..... ☐ ☐ Which joints? ____________

Do You Have Any Allergies? ☐ ☐

☐ Latex ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Aspirin ☐ Local Anesthetics ☐ Other ______

Women: Are you pregnant ☐ ☐ Do you take Birth Control Pills? ☐ ☐

Are You Currently Taking Any Medications (including over the counter and herbal remedies)? .... ☐ ☐

Please List: ____________________________

____

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____

____

____

Medical History Update

Date	Changes	Initial