

## Patient Registration

First name: \_\_\_\_\_ Last name: \_\_\_\_\_  
Preferred name: \_\_\_\_\_  
Parent/Legal guardian(s) if under the age of 18: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Birth date: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Sex: \_\_\_\_\_ Female \_\_\_\_\_ Male  
Marital status: \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed  
Emergency contact name and number: \_\_\_\_\_  
How did you hear about us: \_\_\_\_\_  
Whom may we thank for referring you: \_\_\_\_\_

## Primary Dental Insurance Information

Name of Insured: \_\_\_\_\_  
Relationship to Insured: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other  
Insured Social Security: \_\_\_\_\_ Insured DOB: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
Insurance City, State, Zip: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Employment Status: \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Retired

**\*\*If you have Secondary Insurance, please inform the receptionist**

## Authorizations

It will be held in confidence and it is my responsibility to inform the office in any changes of address, employment information, insurance information. I authorize the release of **ALL** information necessary to secure benefits otherwise payable to me. I assign directly to **EVERGREEN PROSTHODONTIC ASSOCIATES, LLC** all insurance payment otherwise payable to me. I understand that I am responsible for the full balance, including but not limited to third party collections fees, court fees, filing fees, and attorney fees. I affirm that my signature represents my agreement to all the above mentioned terms.

Signature of Patient, Parent, or Guardian

Date

# Medical and Dental History

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please fill out the form completely to the best of your ability. Health problems that you may have, or medication(s) that you may be taking may have an important interrelationship with the dental care you receive. Thank you.

Name of **Primary care physician** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
(First and last name, please)

Address/Location of Primary care Physician: \_\_\_\_\_  
List any prior **Hospitalizations or surgeries** including the year and reason for hospitalization or surgery: \_\_\_\_\_

Have you ever had a serious head or neck injury? If yes, explain: \_\_\_\_\_  
Please list any **medication(s)** you are currently taking, including dosage and frequency: \_\_\_\_\_

Do you take, or have you taken Phen-Fen, Redux, Bonivia, Fosamax, Actonel, Didronel, Shelid, Aredia, Zometa? (please circle) \_\_\_\_\_  
Are you on a **special diet**? If yes, explain: \_\_\_\_\_  
Do you use **tobacco**? If yes, how much and how often? \_\_\_\_\_ Smoke or smokeless (please circle) \_\_\_\_\_  
Do you use **controlled substances**? If yes, please name and include the dosage and frequency: \_\_\_\_\_  
Have you ever had **prolonged or unusual bleeding**? If yes, explain: \_\_\_\_\_

**Women Only:** Are you  Pregnant/Trying to get pregnant?  Nursing?  Taking Oral Contraceptives?

Are you **allergic** to any of the following?  Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  
 Other: \_\_\_\_\_ Please explain the reaction \_\_\_\_\_

## Do you have, or have you had, any of the following?

- |   |  |  |  |  |
|---|--|--|--|--|
| <input type="checkbox"/> AIDS/HIV positive      | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Scarlet Fever       |
| <input type="checkbox"/> Alzheimer's disease    | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Shingles            |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sinus Trouble       |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Spina Bifida        |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Stomach/Intestinal  |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pace Maker      | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Swelling of Limbs   |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Thyroid Disease     |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tonsillitis         |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Tumors or Growth    |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis        | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease    |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism            | <input type="checkbox"/> Yellow Jaundice     |

Have you ever had a **serious illness** not listed above? If yes, please explain: \_\_\_\_\_

Have you ever had a **reaction to local anesthetic**? If yes, please explain: \_\_\_\_\_

Have you ever had **complications or illness following dental treatment**? If yes, please explain: \_\_\_\_\_

Are you **currently in any pain**? If yes, please explain: \_\_\_\_\_

When was your last dental checkup? \_\_\_\_\_ Last dental cleaning? \_\_\_\_\_ X-Rays? \_\_\_\_\_

What is the name of your previous Dentist? \_\_\_\_\_ Address/Location: \_\_\_\_\_

Have you ever been treated for **Active Periodontal Disease**? If yes, how long ago? \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

If you could change anything at all about your smile, what would it be? \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. If I ever have any change in my health condition or the medications I take, I will inform the Doctor on my next appointment.

Signature of Patient, Parent, or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_