

North Channel Dentistry

WELCOME!!!

REGISTRATION FORM

Section I:	Patient Information	Date _____
Name: _____ I Prefer to be called: _____		
Address: _____ City: _____ State: _____ Zip _____		
Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____		
The best time to contact me is: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. On my <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Email		
Date of Birth: _____ Social Security Number: _____		
Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
If Student, Name of School _____ City/State _____ <input type="checkbox"/> FT <input type="checkbox"/> PT		
Spouse or Parent's Name _____ Employer _____ Work Phone _____		
Whom may we thank for referring you? _____		
Person to contact in case of emergency _____ Phone _____		
Email Address _____ Would you like to receive our e-newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Section II	Responsible Party
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name _____ Relationship to Patient: _____	
Address _____	
City _____ State _____ Zip _____ Phone (____) _____	
Employer _____ Work Phone (____) _____ SSN# _____	

Section III	Insurance Information
Name of Insured _____ DOB _____ Relationship to Patient _____	
SSN#: _____ Name of Employer: _____ Work Phone: (____) _____	
Address of Employer: _____ City _____ State _____ Zip _____	
Insurance Company: _____ Group # _____ ID# _____	
Ins Co Address: _____ INS Co. Phone: _____	
***** DO YOU HAVE ANY ADDITIONAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, COMPLETE THE FOLLOWING *****	
Name of Insured _____ DOB _____ Relationship to Patient _____	
SSN#: _____ Name of Employer: _____ Work Phone: (____) _____	
Address of Employer _____ City _____ State _____ Zip _____	
Insurance Company _____ Group # _____ ID# _____	
Ins Co Address: _____ INS Co. Phone: _____	

**Have you ever had any of the following?
Please check those that apply:**

PATIENT NAME: _____

- | | | |
|--|---|---|
| <input type="checkbox"/> AIDS or HIV infection | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stomach Problems/Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tumors |
| _____date | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Winded Easily |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Mental Disorders | Drug Allergies: |
| <input type="checkbox"/> Cancer /Leukemia | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Sulfa drugs |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Any Metals (e.g. nickel) |
| <input type="checkbox"/> Fainting/Seizures | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Latex Rubber |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Snoring or sleep apnea | |

MEDICATION (s) Please list any medication(s), dose and reason for taking them _____

How long has it been since your last dental cleaning? _____ Have you ever been treated by a periodontist (gum specialist)? Yes No

Do your gums bleed while brushing or flossing? Yes No

Are your teeth sensitive to HOT or COLD liquids/foods? Yes No

Are your teeth sensitive to SWEET or SOUR liquids/foods? Yes No

Do you feel pain to any of your teeth? Yes No

Do you have any sores or lumps in or near your mouth? Yes No

Have you ever experienced any of the following problems in your jaw?

- | | |
|---|---|
| <input type="checkbox"/> Clicking | <input type="checkbox"/> Pain (Joint, Ear, Side Face) |
| <input type="checkbox"/> Difficulty in opening or closing | <input type="checkbox"/> Difficulty in chewing |

Do you have frequent headaches? Yes No

Do you clench or grind your teeth? Yes No

Do you bite your lips or cheeks frequently? Yes No

Have you ever had any difficult extractions in the past? Yes No

Have you ever had prolonged bleeding following extractions? Yes No

Have you ever had orthodontic work? Yes No

Does the dental office make you anxious or nervous? Yes No

Have you been hospitalized within the last five years? Yes No

Do you like your smile? Yes No If NO, please explain _____

Would you like more information on straightening your teeth Yes No **OR** Whitening your teeth Yes No

Do you wear dentures or partials? Yes (Date of placement) _____ No

Are you happy with your dentures? Yes No (Please Explain) _____

Do you use tobacco? Pack per day? ____ Years? ____ Do you chew tobacco? Years? _____ Yes No

Are you wearing contact lenses? Yes No Have you ever had oral hygiene instructions? Yes No

- If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information to third party payers and /or health practitioners.

Date: _____

Signature of patient, parent or guardian _____