Signature Care Dentistry
750 Princeton Ave. Suite #1 • Zanesville, OH • 43701 • (740) 453-3089

PATIENT REGISTRATION & MEDICAL/DENTAL HISTORY

Thank you for choosing our practice to meet your dental health needs. Please complete both sides of this form so that we may provide you with the best possible care.

Date _____

Patient Name _____ Date of Birth _____ Sex: ☐ Male ☐Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Soc. Sec. # _____

Email Address _____ Marital Status: ☐Single ☐Mar ☐Sep ☐Div ☐Wid

Employer _____ Occupation _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Person to Contact in Case of an Emergency _____ Phone _____

Preferred Pharmacy _____ Phone _____ How did you hear about us? _____

RESPONSIBLE PARTY

Person Responsible for Account _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Phone _____ Employer _____ Soc. Sec. # _____ Date of Birth _____

INSURANCE INFORMATION

Primary Dental Insurance

Name of Insured _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Soc. Sec.# _____ Insurance Company _____

Group # _____ Policy/ID # _____ Ins Co Phone _____

Ins Co Address _____ City _____ State _____ Zip _____

Secondary Dental Insurance

Name of Insured _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Soc. Sec.# _____ Insurance Company _____

Group # _____ Policy/ID # _____ Ins Co Phone _____

Ins Co Address _____ City _____ State _____ Zip _____

PATIENT DENTAL HISTORY

Name of Previous Dentist _____ Telephone _____

Date of Last: Dental Visit _____ Cleaning _____ Full Mouth X-ray _____ Bitewing X-rays _____

What is the reason for your visit today? _____

Are you having dental problems now? ☐YES ☐NO If yes, please describe: _____

Have you ever responded adversely to medical or dental treatment? ☐YES ☐NO

Have you ever been advised to be pre-medicated prior to any dental treatment? ☐YES ☐NO

Current Medications _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication or substance? ☐YES ☐NO

If yes, list _____

Please check "Yes" or "No" for each item.

	Yes	No
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks regularly?	☐	☐
Do you mouth breath while awake or asleep?	☐	☐
Do you have tired jaws, especially in the morning?	☐	☐
Do you frequently get cold sores, blisters and any other oral lesions?	☐	☐
Do you smoke/chew tobacco?	☐	☐
If yes, how much? _____		
Do you have difficulty chewing on either side of the mouth?	☐	☐
Does food tend to become caught in between your teeth?	☐	☐
Are you happy with your smile?	☐	☐
Are you pleased with the color of your teeth?	☐	☐
Would you like to keep all of your teeth all of your life?	☐	☐

	Yes	No
Have you ever had orthodontic treatment?	☐	☐
Have you ever had oral surgery?	☐	☐
Have you ever had periodontal treatment?	☐	☐
Have your parents experienced gum disease or tooth loss?	☐	☐
Have you ever had your teeth ground or bite adjusted?	☐	☐
Have you noticed any loose teeth or a change in your bite?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced:		
Clicking or popping of the jaw?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty opening or closing the mouth?	☐	☐
Headaches, neckaches or shoulder aches?	☐	☐
Sore muscles (neck, shoulders)?	☐	☐
Have you noticed any mouth odors or bad tastes?	☐	☐
Do you feel nervous about having dental treatment?	☐	☐
If yes, what is your biggest concern? _____		
Have you ever had an upsetting dental experience?	☐	☐
If yes, please describe _____		

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

Please check the box of any condition you may have had.

☐AIDS or HIV Infection	☐Blood Transfusion	☐Heart Disease or Attack	☐Psychiatric Care
☐Allergies to Anesthetics	☐Cancer, Leukemia	☐Heart Murmur	☐Recent Weight Loss
☐Allergy to Colored Dyes	☐Chemical Dependency	☐Heart Pacemaker	☐Respiratory Problem
☐Allergy to Latex	☐Chemotherapy/Radiation Therapy	☐Hemophilia	☐Rheumatic Fever
☐Angina Pectoris	☐Chronic Diarrhea	☐Hepatitis, Jaundice or Liver Disease	☐Sinus Problems
☐Arthritis/Rheumatism	☐Circulatory Problems	☐High Blood Pressure	☐Special Diet
☐Artificial Heart Valves	☐Contact Lenses	☐Hypoglycemia	☐Stroke
☐Artificial Joints	☐Diabetes	☐Kidney Problem	☐Swollen Neck Glands
☐Aspirin Taken Daily	☐Epilepsy/Seizures	☐Low Blood Pressure	☐Thyroid Disease
☐Asthma	☐General Allergies * (List Below)	☐Mitral Valve Prolapse	☐Tuberculosis
☐Back Problems	☐Glaucoma	☐Nervous Problems	☐Ulcer
☐Blood Disease	☐Headaches	☐Pre medicate	☐Venereal Disease

General Allergies _____

Are you under medical treatment now? ☐YES ☐NO If yes, for what condition? _____

Have you ever taken Phen-Fen/Redux? ☐YES ☐NO Have you seen a cardiologist since taking it? ☐YES ☐NO

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications including bisphosphonates? ☐YES ☐NO

Have you had a recent transfusion? ☐YES ☐NO If patient is a child, what is his/her current weight? _____

Women - Are you:

Pregnant or think you might be pregnant? ☐YES ☐NO Nursing? ☐YES ☐NO Taking oral contraceptives? ☐YES ☐NO

Is there anything else we should know about your medical history? _____

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care, to third party payers and/or health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of Patient (Parent/Guardian if minor) *Date*

_____

Staff/Doctor's Signature *Date*