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:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_____ Social Security Number:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School_____ City/State_____ ☐ FT ☐ 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? ☐ Yes ☐ No

Section II Health and Dental History

Are you taking any medications now, including daily dosage of aspirin? Yes No
If so, please list name and dosage. _____

Are you aware of having an allergic reaction to any medications or substance? Yes No
If so, for what? _____

Have you seen an ENT (ear, nose, and throat doctor)? Yes No Name_____

Have you seen a Chiropractor? Yes No Name_____

Have you seen a Neurologist? Yes No Name_____

Have you had braces? Yes No Name of Orthodontist _____

Have you ever had any cosmetic procedures? Yes No If so, for what?_____

Would you like your smile to look better or different? Yes No

Atwood FAMILY DENTISTRY

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart concerns	Yes	No	Trigeminal Neuralgia	Yes	No
Congenital Heart Disease	Yes	No	Tingling in Arms/Fingers	Yes	No
Heart Murmur	Yes	No	Psychiatric/Psychological	Yes	No
High Blood Pressure	Yes	No	Neurological Disorders	Yes	No
Mitral Valve Prolapse	Yes	No	Insomnia/Frequent waking	Yes	No
Artificial Heart Valve	Yes	No	Dizziness	Yes	No
Pacemaker	Yes	No	Ringing Ears	Yes	No
Stroke	Yes	No	Loose teeth	Yes	No
Asthma	Yes	No	Posture Problems	Yes	No
Liver Disease/Jaundice	Yes	No	Clenching	Yes	No
Latex Sensitivity	Yes	No	Grinding	Yes	No
Artificial Joints	Yes	No	Facial Pain	Yes	No
Kidney Trouble	Yes	No	Sensitive Teeth	Yes	No
Radiation Chemotherapy	Yes	No	Neck Ache	Yes	No
Epilepsy Seizures	Yes	No	Difficulty Swallowing	Yes	No
Bell's Palsy	Yes	No	Difficulty Chewing	Yes	No
Diabetes	Yes	No	Headaches	Yes	No
Hepatitis	Yes	No	Jaw Pain	Yes	No
AIDS/ HIV	Yes	No	Limited Opening	Yes	No
Sickle Cell Disease	Yes	No	Congested Ears	Yes	No
Do you smoke or chew tobacco?	Yes	No	Do your gums bleed?	Yes	No

Do you have or have you had any disease or condition not listed?_____

Women: Are you pregnant?_____ Nursing_____ Taking birth control pills?_____

Section III

Dental Insurance Information

Name of Subscriber _____ DOB_____

Relationship to Patient _____ Subscriber #_____Group#_____

Dental Insurance Company Name _____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any changes in my health or medication.

Signature _____ Date _____