# DENTAL CARE REGISTRATION FORM

Today's Date:_____

Welcome to our practice! Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help. We look forward to working with you in maintaining your dental health.

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Patient last name: | First: | MI: | Preferred name: |
| If minor, parents' names: | | | |
| Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated | | Sex ☐ M ☐ F | Birth date: |
| Occupation: | Employer: | | |
| Other family members seen here: | | | |

## CONTACT INFORMATION

| | | | |
|---|---|---|---|
| Address: | City: | State: | Zip Code: |
| Patient SSN: | | | |
| Home phone: | Cell phone: | E-Mail: | |

**Cell Phone Use Policy:**

I provide consent to *TNT Dental Care* to use my cell phone number to ☐ call or ☐ text (choose one or both) regarding appointments, treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

**Inital:** _____

Whom may we thank for referring you?

☐ Yelp ☐ Facebook ☐ Website ☐ Google ☐ Friend's Name_____ ☐ Other_____

When is the best time to contact you? ☐ Morning ☐ Afternoon ☐ Evening

## PRIMARY DENTAL INSURANCE INFORMATION

(Please give your insurance card and photo identification card to the receptionist.)

| | | |
|---|---|---|
| Subscriber's Name: | | Relationship to patient: |
| Subscriber Birth date: | SSN or Subscriber ID#: | Address (if different from patient's): |
| Occupation: | Employer: | |
| Insurance Company Name: | | |

## ADDITIONAL DENTAL INSURANCE INFORMATION

Is patient covered by additional dental insurance? ☐ Yes ☐ No

| | | | |
|---|---|---|---|
| Subscriber's Name: | | Relationship to patient: | |
| Subscriber Birth date: | SSN or Subscriber ID#: | Address (if different from patient's): | |
| Occupation: | | Employer: | |
| Insurance Company Name: | | | |
| | | | |

## DENTAL INFORMATION

| What is the reason for you dental visit today? | Are you currently in dental discomfort? ☐ Y ☐ N |
|---|---|

| Date of last dental exam: | What was done at that time: | Date of last dental xrays: |
|---|---|---|
| Do you wear dentures? ☐ Y ☐ N | How do you feel about your smile? | Would you like your teeth to be whiter? ☐ Y ☐ N |

Check if you have/ had problems with any of the following:

| | | | |
|---|---|---|---|
| ☐ Bad breath | ☐ Food collection between teeth | ☐ Periodontal treatment | ☐ Sensitivity to sweets |
| ☐ Bleeding gums | ☐ Grinding or clenching teeth | ☐ Sensitivity to cold or hot | ☐ Sensitivity when biting |
| ☐ Clicking or popping jaw | ☐ Cold sores/Fever blisters/Herpes | ☐ Pain in the jaw joints | ☐ Sores or growths in mouth |
| ☐ Frequent headaches | ☐ Prolonged bleeding after extraction | ☐ Dry mouth | ☐ Any head, neck, or jaw injuries |

## MEDICAL INFORMATION

| Are you under a physician's care? ☐ Y ☐ N | Physician's Name | Physician's Phone: |
|---|---|---|
| Do you use tobacco? ☐ Y ☐ N | Do you use controlled substances? ☐ Y ☐ | Any surgical operation or serious illness? ☐ Y ☐ N |

Women: Are you pregnant? ☐ Y ☐ N Are you nursing? ☐ Y ☐ N Are you taking oral contraceptives? ☐ Y ☐ N

Check whether you have had any of the following:

| | | | |
|---|---|---|---|
| ☐ AIDS/HIV positive | ☐ Congenital heart disorder | ☐ Hemophilia | ☐ Psychiatric Care |
| ☐ Anemia | ☐ Diabetes Type I or II | ☐ Heart Attack/Failure | ☐ Rheumatic Fever |
| ☐ Angina | ☐ Drug Addiction | ☐ Heart Murmur | ☐ Stomach/Intestinal Disease |
| ☐ Arthritis/Gout | ☐ Heart Trouble/Disease | ☐ Heart Pacemaker | ☐ Severe or rapid weight loss |
| ☐ Artificial Heart Valve | ☐ Emphysema | ☐ Hepatitis, liver | ☐ Sinus Trouble |
| ☐ Artificial Joint | ☐ Easily Winded | ☐ High Blood Pressure | ☐ Sleep Disorder |
| ☐ Asthma | ☐ Epilepsy or Seizures | ☐ Hives or Rash | ☐ Stroke |
| ☐ Blood Disease | ☐ Excessive, abnormal bleeding | ☐ Irregular heartbeat | ☐ Thyroid Disorder |
| ☐ Blood transfusion | ☐ Fainting Spells/ Dizziness | ☐ Kidney problems | ☐ Tuberculosis |
| ☐ Bruise easily | ☐ Frequent cough, Bronchitis | ☐ Low blood pressure | ☐ Tumors or growths |
| ☐ Cancer/Chemo/Radiation | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Ulcers |
| ☐ Chest pain upon exertion | ☐ GE Reflux, heartburn | ☐ Osteoporosis | ☐ Other |

List any allergies:

☐ Anesthetic (local) ☐ Aspirin ☐ Codeine ☐ Latex ☐ Metal ☐ Penicillin ☐ Sulfa Drugs ☐ Other_____

List any medications currently taking:

## IN CASE OF EMERGENCY

| Name of local friend or relative: | Relationship to patient: | Cell or Home phone: |
|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to TNT Dental Care. I understand that I am financially responsible for any balance. I also authorize TNT Dental Care or insurance company to release any information required to process my claims.

Patient/Guardian signature Date