Gainesville Dental Arts
PATIENT REGISTRATION

ID: ______ Chart ID: ____________________

First Name: ____________________ Last Name: ____________________ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: ____________________ Last Name: ____________________ Middle Initial: ____

Address: ____________________

City : ____________________ State ________ Zip ______ Relationship To Patient ____________

Home Ph: ____________ Work Ph: ____________ Ext: ______ Cell ____________

Birth Date: ____________ Soc Sec: ____________ Drivers Lic: ____________

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: ____________________

City: ____________________ State: ________ Zip: ________

Home Phone: ____________ Work Phone: ____________ Ext: ______ Cellular: ____________

Sex: ◯ Male ◯ Female

Is Patient Minor ◯ Yes ◯ No

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed ◯ Partnered Far

Birth Date: ____________ Age: ______ SSN: ____________ Drivers Lic: ____________

E-mail: ____________________ ☐ I would like to receive correspondences via e-mail and text-message.

Employment/School Information:

☐ Employed ☐ Student Other ____________

Employer/School Name ____________________

Employer/School Address ____________________

Additional Comments:

____

Primary Insurance Information

Insured's Name ____________________ Relationship to Insured: ____________

Insured's Employer ____________________ Ins. Co ____________

Ins. Co. Address ____________________

Insures Soc. Sec: ____________ Insured Birth Date: ____________

Group# ________ Plan ________ Member/Policy# ____________ Phone# ____________

Secondary Insurance Information

Name of Insured: ______________________ Relationship to Insured ______________________

Insured's Employer: ______________________ Inc. Co ______________________

Ins. Co. Address ______________________

Insured SSN: ______________________ Insured Birth Date: ______________________

Group# __________ Plan __________ Member/Policy# __________ Phone# __________

Dental History

Please check any of the following that apply to you

Sensitivity to ☐ Hot ☐ Cold ☐ Sweet ☐ Pressure **Where ?** ☐ UR ☐ LR ☐ UL ☐ LL

	Yes	No		Yes	No		Yes	No
Headache	◯	◯	Teeth feel Painful	◯	◯	Difficulty in opening or closing your jaw	◯	◯
Neck Pain	◯	◯	Jaw joint pain	◯	◯	Bite your lips or cheeks frequently	◯	◯
Earaches	◯	◯	Clicking in your jaw	◯	◯	Grinding,clenching teeth	◯	◯
Braces	◯	◯	Teeth or filling breaking	◯	◯	Bleeding, swollen, irrigated gums	◯	◯
Bad Breath	◯	◯	Partial Dentures	◯	◯	Ever worn a bite plate or other appliance	◯	◯
Ear Ringing	◯	◯	Blisters on lip or mouth	◯	◯	Gums bleed while brushing or flossing.	◯	◯
Dentures	◯	◯	Tipped,shifting teeth	◯	◯	Difficulty extractions in the past	◯	◯
Dry Mouth	◯	◯	Difficulty in chewing	◯	◯	Loose,broken teeth or broken filling	◯	◯
Sores or lumps in or near your mouth				◯	◯	Food Collection between teeth	◯	◯

If I could change my smile,I would :	Yes	No
Replace old crowns that don't match	◯	◯
Replace black metal fillings with tooth colored restorations	◯	◯
Close spaces	◯	◯
Repair chipped teeth	◯	◯
Replace missing teeth	◯	◯
Have a smile makeover	◯	◯
Make it whiter	◯	◯
Make it straighter	◯	◯
Do you smoke or use chewing tobacco?	◯	◯

Your last oral cancer screening date __________ Your last cleaning date __________

How much? __________ For how long __________

Your Last complete X-Rays date __________

Name of the previous Dentist __________ Why did you leave previous dentist ? __________

Address ______________________ Phone Number __________

What is the most important thing to you about your future smile and dental health? __________

What is the most important thing to you about your dental visit today? __________

Physician's name __________ Date of last visit __________ Blood Pressure __________

Physician's address __________

Have you had any serious illness or operations ◯ Yes ◯ No If yes, please describe __________

Have you ever had a blood transfusion ◯ Yes ◯ No If yes, give approximate dates __________

(Women) Are you pregnant? ◯ Yes ◯ No Due date __________ Nursing? ◯ Yes ◯ No Taking birth control pills? ◯ Yes ◯ No

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

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	◯	◯	Chest Pains	◯	◯	Frequent Diarrhea	◯	◯	High Cholesterol	◯	◯	Rheumatic Fever	◯	◯
Alzheimer's Disease	◯	◯	Cold Sores/Fever Blisters	◯	◯	Frequent Headaches	◯	◯	Hives or Rash	◯	◯	Sleep Apnea	◯	◯
Anaphylaxis	◯	◯	Congenital Heart Disorder	◯	◯	Genital Herpes	◯	◯	Hypoglycemia	◯	◯	Renal Dialysis	◯	◯

Anemia	◯	◯	Convulsions	◯	◯	Glaucoma	◯	◯	Irregular Heartbeat	◯	◯	Heart Surgery	◯	◯
Angina	◯	◯	Cortisone Medicine	◯	◯	Hay Fever	◯	◯	Kidney Problems	◯	◯	Rheumatism	◯	◯
Arthritis/Gout	◯	◯	Diabetes	◯	◯	Heart Attack/Failure	◯	◯	Leukemia	◯	◯	Osteoporosis	◯	◯
Artificial Heart Valve	◯	◯	Drug Addiction	◯	◯	Heart Murmur	◯	◯	Liver Disease	◯	◯	Shingles	◯	◯
Artificial Joint	◯	◯	Easily, Winded	◯	◯	Heart Pacemaker	◯	◯	Low Blood Pressure	◯	◯	Scarlet Fever	◯	◯
Asthma	◯	◯	Emphysema	◯	◯	Heart Trouble/ Disease	◯	◯	HIV Positive	◯	◯	Spina Bifida	◯	◯
Blood Disease	◯	◯	Epilepsy or Seizures	◯	◯	Hemophillia	◯	◯	Lung Disease	◯	◯	Stroke	◯	◯
Blood Transfusion	◯	◯	Excessive Bleeding	◯	◯	Hepatitis A	◯	◯	Rheumatism	◯	◯	Seizures	◯	◯
Breathing Problem	◯	◯	Excessive Thirst	◯	◯	Hepatitis B or C	◯	◯	Pacemaker	◯	◯	Tonsillitis	◯	◯
Bruise Easily	◯	◯	Fainting Spells/Dizziness	◯	◯	Herpes	◯	◯	Thyroid Disease	◯	◯	Tuberculosis	◯	◯
Cancer	◯	◯	Frequent Cough	◯	◯	High Blood Pressure	◯	◯	Venereal Diseases	◯	◯	Ulcers	◯	◯
Recent weight Loss	◯	◯	Psychiatric Care	◯	◯	Mitral Valve Prolapse	◯	◯	Sickle Cell Disease	◯	◯	Respiratory Problems	◯	◯
Radiation Treatment	◯	◯	Yellow Jaundice	◯	◯	Pain in Jaw Joints	◯	◯	Sinus Trouble	◯	◯	Thyroid Disease	◯	◯
Venereal Disease	◯	◯	Rheumatic Fever	◯	◯	Parathyroid Disease	◯	◯	Swelling of Limbs	◯	◯	Tuberculosis	◯	◯
HPV(Human Papilloma Virus)	◯	◯	Stomach/Intestinal Disease	◯	◯	Nervousness/Depression	◯	◯	Heart Lesions (Congential)	◯	◯	Tumors of Growths	◯	◯

Are you allergic or have you reacted adversely to any of the following medications?

	Yes	No		Yes	No		Yes	No		Yes	No	
Aspirin	◯	◯	Percodan	◯	◯	Tetracycline	◯	◯	Valium	◯	◯	Others ____________
Darvon	◯	◯	Latex	◯	◯	Codeine	◯	◯	Penicillin	◯	◯	
Nitrous Oxide	◯	◯	Local Anesthetic	◯	◯	Erythromycin	◯	◯	Sulfa	◯	◯	____________

Have you ever taken any of the following medications?

	Yes	No		Yes	No
Actonel	◯	◯	Zometa	◯	◯
Aredia	◯	◯	Boniva	◯	◯
Fosamax	◯	◯	Herbal	◯	◯
Reclast	◯	◯	Supplements	◯	◯

Are you under a physician's care?What for?

____

What medications are you currently taking?

____

Family Physician ____________________ Phone Number ____________________

Consent:
The undersigned here by authorizes Doctor to take X-rays,study models,photographs,or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any all forms of treatment and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Patient Signature(Parent if child) Date ____________ Dentist Signature