MICHELLE A. GIFFORD
D.D.S.
Family Dentistry

Patient Registration

Patient's Name | **Birth date** | **Age** | **Sex: M F**

Home Address	**City**	**State**	**Zip**
Home Phone # **Work Phone #** **YOUR cell phone #**	***Please Circle One:***		
Your Employer	Single, Married, Separated, Widow		**Your Soc Sec. # (is not necessary if paying at the time of service)**
Occupation			

Are you a full time student? ☐Yes ☐ No

If patient is minor we need: *Mother's Name & Birth date* *Father's Name & Birth date*

Person paying this bill **YOUR Driver's License Number**

Name of spouse (or parent if minor) **YOUR E-mail address**

Spouse's (or parent's) employer **Spouse's Soc. Sec. #** **Work phone #**

EMERGENCY INFORMATION

Name, Address, & Telephone of A relative not living with you:

How did you hear about our office?

Reason for your visit today ?

DENTAL INSURANCE INFORMATION (Primary Carrier)	**If you have a dual insurance coverage, complete this for the second coverage (this office bills primary ins only)**
Insured's name DOB SS#	Insured's name DOB SS#
Insured's employer	Insured's employer
Insurance Co	Insurance Co
Insurance Co Address	Insurance Co Address
Phone #	Phone #
Group # Policy #	Group # Local #

Patient Signature (or Parent of Child) **Date** **Dentist's Signature**

DENTAL HISTORY

Please check the following:	YES	NO
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	☐	☐
-Headaches, ear aches, neck or jaw joint pain	☐	☐
-Mouth ulcers or cold sores	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath	☐	☐
Do you have or have you had any of the following?	☐	☐
-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Gum treatments	☐	☐

Please share the following dates:

-Your last cleaning ___ / ___

-Your last oral cancer screening ___ / ___

-Your last complete X-Rays ___ / ___

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

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

	YES	NO
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco? How much? For how long?	☐	☐
If I could change my smile, I would:		
-Make my teeth whiter	☐	☐
-Make my teeth straighter	☐	☐
-Close spaces	☐	☐
-Replace metal fillings with tooth colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Have a smile makeover	☐	☐

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____

_____

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

MEDICAL HISTORY

Please check any of the following that apply to you:

Y N	Y N	Y N	Y N
☐ ☐ Allergies (Seasonal)	☐ ☐ Emphysema	☐ ☐ Osteoporosis	☐ ☐ Ulcers
☐ ☐ Anemia	☐ ☐ Fainting	☐ ☐ Jaundice	☐ ☐ Other:
☐ ☐ Arthritis	☐ ☐ Glaucoma	☐ ☐ Jaw Joint Pain	
☐ ☐ Artificial Joints	☐ ☐ Head Injuries	☐ ☐ Pacemaker	**For WOMEN Only**
☐ ☐ Artificial Heart Valve	☐ ☐ Heart Disease	☐ ☐ Pre-Medication	☐ ☐ Birth Control Pills
☐ ☐ Asthma	☐ ☐ Heart Conditions	☐ ☐ Radiation (head/neck)	☐ ☐ Breast-feeding
☐ ☐ Back Problems	☐ ☐ Heart Murmur	☐ ☐ Respiratory Problems	☐ ☐ Pregnant
☐ ☐ Cancer	☐ ☐ other Heart conditions	☐ ☐ Seizures	☐ ☐1-3 mos,3-6 mos,6-9mos,
☐ ☐ Chemotherapy	☐ ☐ Hepatitis A B C	☐ ☐ Stomach Problems	
☐ ☐ Circulatory Problems	☐ ☐ High Blood Pressure	☐ ☐ Stroke	
☐ ☐ Diabetes	☐ ☐ Low Blood Pressure	☐ ☐ Swelling – Feet/Ankles	
☐ ☐ Dizziness	☐ ☐ Kidney Disease	☐ ☐ Thyroid Disease	
☐ ☐ Excessive Bleeding	☐ ☐ Liver Disease	☐ ☐ Tuberculosis	

Do you have any of the following drug allergies?

☐ ☐ Aspirin	☐ ☐ Penicillin
☐ ☐ Codeine	☐ ☐ Sulfa
☐ ☐ Erythromycin	☐ ☐ Tetracycline
☐ ☐ Ibuprofen	☐ ☐ Tylenol
☐ ☐ Latex	☐ ☐ Other

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

_____

Are you taking any medications? What?

_____

_____

_____

Is there any other medical or dental information we should know about? _____

_____