Premier Dental
ASSOCIATES, INC.

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Complete Dental Care &Facial Cosmetics

REGISTRATION HISTORY

DATE: ____/____/____

BIRTHDATE: ____/____/____

NAME: ______________________________ SOCIAL SECURITY# ____-____-____

ADDRESS: ______________________________
(Street) (Apt.) (Email)

____
(City) (State) (Zip)

HOME PHONE #: ____-____-____ BUSINESS#: ____-____-____ CELLULAR #: ____-____-____

NAME OF SPOUSE: ______________________________ ______________________________
(Email)

NAME OF PARENT (If child): ______________________________

OCCUPATION: ______________ EMPLOYER______________ PHONE: ____-____-____

EMPLOYER'S ADDRESS: ______________________________

SPOUSE'S OCCUPATION: ______________ EMPLOYER: ______________ PHONE: ____-____-____

EMPLOYER'S ADDRESS: ______________________________

DO YOU HAVE DENTAL INSURANCE? | Secondary Carrier

INSURANCE COMPANY: ______________ | ______________

POLICY #: ______________ | ______________

WHO WILL PAY FOR ACCOUNT?: ______________________________

IF USING CREDIT CARD, NAME: ______________________________

IN CASE OF EMERGENCY, NOTIFY: ______________________________

PHYSICIAN: ______________________________ PHONE: ____-____-____

ADDRESS: ______________________________

WHY DID YOU DECIDE TO USE OUR DENTAL OFFICE?: ______________________________

IF REFERRED, WHOM MAY WE THANK FOR REFERRING YOU?: ______________________________

WHAT IS THE REASON FOR YOUR VISIT TODAY?: ______________________________

____

____

DENTAL HISTORY

Please circle the appropriate answer:

1. Regular dental care in the past, Date: ____/____/____ Yes / No
2. Happy with appearance of teeth?.......... Yes / No
3. Chew on both sides of mouth?.......... Yes / No
4. Teeth usually sensitive to:
   Cold ☐ Sweets ☐ Hot ☐ Biting Pressure ☐
5. Frequent Headaches? .... Yes / No
6. Bothered by injections? .... Yes / No
7. Had "laughing gas" during treatment? .... Yes / No
8. Had complete mouth X-ray? .... Yes / No
   If "Yes", please give date: ____/____/____
9. Pleased with health of teeth? .... Yes / No
10. Gums bleed when brushing? .... Yes / No
11. Unusual swelling in mouth? .... Yes / No
12. Unusual / frequent pain in: Teeth ☐ Jaw joints ☐ Jaws ☐ Ears ☐
13. Frightened by treatment? .... Yes / No
14. Have you worn braces?.......... Yes / No
15. Have you been told you have periodontal disease?.......... Yes / No
16. How often do you clean your teeth / gums? ______________
17. Have you ever experienced a bad taste in your mouth or offensive breath.......... Yes / No
18. Do you grind your teeth? .... Yes / No
19. If there was a simple inexpensive way to brighten your teeth, would you be interested? .... Yes / No
20. If you could change one thing about your smile, what would it be?
    ____
    ____
21. Why did you leave your last dentist? ______________________________
    ____
22. What did you like most about any dentist you've seen? ______________
    ____

MEDICAL HISTORY

CURRENTLY:

1. Do you have pain or discomfort at this time? .... Yes / No
2. Have you been a patient in the hospital during the past two years? .... Yes / No
3. Have you been under the care of a medical doctor during the past two years? If "Yes" reason: ________ Yes / No
4. Have you taken any medication or drugs during the last two years? .... Yes / No
5. Are you now taking any medication, drugs or pills? If "Yes" List: ________ Yes / No
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? .... Yes / No
   If "yes" please list: ________
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	Yes / No	Stroke	Yes / No	Hepatitis A (infectious)	Yes / No
Heart Disease or Attack	Yes / No	Artificial Joints (hip, Knee, etc.)	Yes / No	Hepatitis B. (serum)	Yes / No
Angina Pectoris	Yes / No	Kidney Trouble	Yes / No	Venereal Disease	Yes / No
Congenital Heart Disease	Yes / No	Ulcers	Yes / No	A. I. D. S.	Yes / No
Heart Murmur	Yes / No	Diabetes	Yes / No	H. I. V. Positive	Yes / No
High Blood Pressure	Yes / No	Thyroid Problems	Yes / No	Cold Sores/Fever Blisters	Yes / No
Arteriosclerosis	Yes / No	Glaucoma	Yes / No	Blood Transfusion	Yes / No
Mitral Valve Prolapse	Yes / No	Cosmetic Surgery	Yes / No	Hemophilia	Yes / No
Artificial Heart valve	Yes / No	Emphysema	Yes / No	Anemia	Yes / No
Heart Pacemaker	Yes / No	Chronic Cough	Yes / No	Sickle Cell Disease	Yes / No
Heart Surgery	Yes / No	Tuberculosis	Yes / No	Bruise Easily	Yes / No
Rheumatic Fever	Yes / No	Asthma	Yes / No	Liver Disease	Yes / No
Arthritis	Yes / No	Hay Fever	Yes / No	Yellow Jaundice	Yes / No
Rheumatism	Yes / No	Allergies or Hives	Yes / No	Epilepsy or Seizures	Yes / No
Pain in Jaw Joints	Yes / No	Sinus Trouble	Yes / No	Fainting or Dizzy Spells	Yes / No
Cortisone Medicine	Yes / No	Radiation Therapy	Yes / No	Nervousness	Yes / No
Drug Addiction	Yes / No	Chemotherapy	Yes / No	Psychiatric Treatment	Yes / No

8. Have you been told by your Physician to be pre-medicated before dental treatment? .... Yes / No
9. When you walk up stairs or take a walk, do you ever have to stop because of a pain in your chest, shortness of breath, or because you are very tired? .... Yes / No
10. Do your ankles swell during the day? .... Yes / No
11. Do you use more than two pillows to sleep? .... Yes / No
12. Have you lost or gained more than 10 pounds in the past year? .... Yes / No
13. Do you ever wake up from sleep, and feel short of breath? .... Yes / No
14. Are you on a special diet? .... Yes / No
15. Has your medical doctor ever said you have cancer or a tumor? .... Yes / No
16. Do you have or have you had any disease, condition, or problems not listed? If "yes" please list: .... Yes / No

____

____

____

For Women Only

Are you pregnant? ☐ Yes, what month? ______ ☐ No Are you nursing? Yes ☐ No ☐ Are you taking birth control pills? Yes ☐ No ☐

I understand the information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature: ________ Date: ____/____/______

CONSENT

The undersigned hereby 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 and all forms of treatment, medication, and therapy, that may be indicated in connection with (name of patient) ________ and further authorize and consent that Doctor choose and employ such assistance as deemed fit, I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 45 days. In the event of a default, I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient: ________ Date: ____/____/______ Witness: ________

Parent or Responsible Party: ________ Relationship to Patient: ________