PATIENT REGISTRATION FORM

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____

TITLE: _____ MIDDLE NAME: _____ NICK NAME: _____

ADDRESS: _____ APT NO: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMAIL: _____ SOCIAL SECURITY NO: _____-___-_____

BIRTH DATE: ___/___/___ REFERRED BY: _____

RESPONSIBLE PARTY: *(ACCOUNT NAME)* TITLE: _____

LAST NAME: _____ FIRST NAME: _____ INITIAL: _____

ADDRESS: _____ APT NO: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NO: _____-___-_____ BIRTH DATE: ___/___/___ SEX: ___

EMPLOYER: _____ EMPLOYER ADDR: _____ EMP PHONE: _____

SPOUSE NAME:

LAST NAME: _____ FIRST NAME: _____

SOCIAL SECURITY NO: _____-___-_____ BIRTH DATE: ___/___/___ SEX: ___

EMPLOYER: _____

EMPLOYER ADDRESS: _____ EMPLOYER PHONE: _____

INSURANCE INFORMATION:

EMPLOYEE NAME: _____

EMPLOYER NAME: _____

INSURANCE CO. NAME: _____

GROUP NO: _____

INS CO PHONE NO: _____

INS CO ADDRESS: _____

OTHER INSURANCE:

EMPLOYEE NAME: _____

EMPLOYER NAME: _____

INSURANCE CO. NAME: _____

GROUP NO: _____

INS CO PHONE NO: _____

INS CO ADDRESS: _____

OTHER FAMILY MEMBERS: PLEASE PROVIDE NAME AND BIRTHDATE

The Facial Beauty INSTITUTE

Gordon P Smith, DDS

COSMETIC AND IMPLANT DENTISTRY

Dental History

Pain	Y	N	Location?
In or near your ears?	☐	☐	
Mouth hurt when clenched?	☐	☐	
Unhealed injuries or Inflamed areas, Growths, or Sore spots?	☐	☐	
Teeth sore to Pressures, Hot, Cold, Sweets, etc.	☐	☐	
If tooth pain, is the pain prolonged?	☐	☐	
Clicking, Popping, or Difficulty Opening or Closing Jaw	☐	☐	
Headaches	☐	☐	
Oral Habits	**Y**	**N**	**How much?**
Smoking?	☐	☐	
Nail Biting?	☐	☐	
Thumb Sucking?	☐	☐	
Clench Teeth Night or Day?	☐	☐	
Other?	☐	☐	
Oral Hygiene	**Y**	**N**	**How much?**
Brushing?	☐	☐	
Flossing?	☐	☐	
Other?	☐	☐	
Dental Visits			
When was your last Dental Exam?			
When was your last Dental Visit?			
When was your last Dental Cleaning?			
When were your last Bitewing x-rays?			
When were your last Full Mouth x-rays?			
Past Dental Experience	**Y**	**N**	
Have you had local anesthetic?	☐	☐	
Complications from extractions?	☐	☐	
ANY of the following: Trench mouth, Candida, Anug, Thrush?	☐	☐	
Do Your Gums Bleed?	☐	☐	
Does Dental Treatment make you nervous?	☐	☐	
Are you happy with your smile?	☐	☐	

Reason for Visit?

Name:_____ **Signature:**_____ **Date:** / /

3255 W Maple Rd
Wixom, MI 48393
(Corner of Wixom & Maple Roads)

Phone: 248-669-4141
Email: Gordon@Dentabyte.com
Website: www.Dentabyte.com

PATIENT MEDICAL HISTORY

PATIENT NAME: _____ **BIRTHDATE:** / /

PHONE: _____ **SOC. SEC. #:** _____

PHYSICIAN NAME: _____ **PHYSICIAN PHONE:** _____

LAST PHYSICAL EXAM: / /

PHARMACY: _____ **PHARMACY PHONE:** _____

MEDICAL ALERTS:

Y N
☐ ☐ Are you taking Birth Control Pills?
☐ ☐ Are you pregnant? If Yes, # of weeks ☐
☐ ☐ Are you nursing?

Y N
☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP: ☐ Heart Rate: ☐

Please mark Y(yes) or N(no) to all of the following:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other: _____

MEDICATIONS:

SIGNATURE: _____ **DATE:** / /