Mortenson Family Dental
Patient Registration

Today's Date

Patient's Name		Preferred Name	
Birth Date	Age		Sex M F
SS #	Single	Married	Child
Home Address			
City	State	Zip	
Home Phone	Cell Phone	Work Phone	
Employer		Full Time Student?	Y N
If patient is a minor:	Mother's Date of Birth	Father's Date of Birth	

Person Responsible for Account (if other than patient)

Name	SS#	
Home Phone	Cell Phone	Work Phone
Employer		

Emergency Contact Information (relative not living with you)

Name	Relationship
Address	Phone

How did you hear about our office?

Yellow Pages	Radio	Health Fair	Newspaper	Magazine
Patient/Relative - Name		Patient/Friend - Name		
Referring Dentist or Orthodontist Name				
Other (please descibe)				

Dental Insurance - Primary		Dental Insurance - Secondary	
Insured's Name		Insured's Name	
Insured's DOB	Insured's SS#	Insured's DOB	Insured's SS#
Ins. Co. Name		Ins. Co. Name	
Ins. Co. Phone #		Ins. Co. Phone #	
Group #	ID #	Group #	ID #

Dental History

Please check any of the following that apply to you:
- ☐ Sensitivity (hot, cold, sweets, pressure)
- ☐ Discomfort when chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth of fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, chipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

What would you like to do to improve your smile?
- ☐ Whiten
- ☐ Straighten
- ☐ Close spaces
- ☐ Replace silver fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match other teeth

Do you have or have you ever had any of the following?
- ☐ Dentures
- ☐ Partial Dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Name of previous dentist ______________________________

City & State ______________________________

Phone number ______________________________

How long has it been since your last cleaning?

less than 1 yr. 1 - 2 yrs 3 - 5yrs over 5 yrs

Why did you leave your previous dentist?

____

What is the most important thing about your visit today?

____

Medical History

- ☐ AIDS/HIV positive
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur/Mitro Valve Prolapse
- ☐ Hepatitis A B C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Pregnant (currently)
  due date: ______________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco User (currently)
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Other ______________________

Allergies:

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Latex
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Percodan
- ☐ Seasonal
- ☐ Sulfa Drugs
- ☐ Valium
- ☐ Other ______________________

What medications do you take? ______________________________

Family Doctor ______________________ Phone Number ______________________

Patient/Parent Signature ______________________ Date ______________________