

## Mortenson Family Dental Patient Registration

Today's Date

Patient's Name		Preferred Name	
Email Address			Sex    M    F
Birth Date    /    /	Age	SS#	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> 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 describe)				

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 or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, chipped or shifting teeth
- Bad breath or bad taste in your mouth

Do you have or have you ever had any of the following?

- Dentures
- Partial Dentures
- Braces
- Periodontal (gum) treatments

How long has it been since your last cleaning?

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

What is the most important thing about your visit today?

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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

Name of previous dentist \_\_\_\_\_

City & State \_\_\_\_\_

Phone number \_\_\_\_\_

Why did you leave your previous dentist?  
\_\_\_\_\_

## 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 \_\_\_\_\_