**Ash Family Dental**
4425 Fulton Drive NW
Canton, OH 44718
330-494-8508

# PATIENT REGISTRATION

*Please complete the following confidential information*

Date: _____

Patient's Name: _____

Patient's Birthday _____ SS#: _____

Single _____ Married _____ Separated _____ Widowed _____ Divorced _____

Home Address: _____

Home Telephone: _____ Cell Phone: _____

Email Address: _____

Patient's Employer: _____ Work Telephone: _____

Patient's Occupation: _____

Parent/Spouse's Name: _____

Parent/Spouse's Birthdate: _____ SS#: _____

Parent/Spouse's Employer: _____ Work Telephone: _____

In Case of Emergency, please contact: _____

Emergency Contact's Relationship to Patient: _____

Emergency Contact's Home Telephone: _____ Work Telephone: _____

Whom may we thank for recommending you to our office? _____

**PRIMARY DENTAL INSURANCE**

Employee Name: _____ Mail Claims to:

Employer: _____ _____

Insurance Co.: _____ _____

Group #: _____ _____

ID #: _____ _____

**SECONDARY DENTAL INSURANCE**

Employee Name: _____ Mail Claims to:

Employer: _____ _____

Insurance Co.: _____ _____

Group #: _____ _____

ID #: _____ _____

_____ _____

Signature Date

***Continued on Back***

# Please circle Yes or No to the Following:

| | | |
|---|---|---|
| Heart Disease | Yes | No |
| Artificial Heart Valve | Yes | No |
| Heart Murmur or Mitral Valve Prolapse | Yes | No |
| High Blood Pressure | Yes | No |
| Angina | Yes | No |
| Heart Attack (Coronary) | Yes | No |
| Heart Surgery | Yes | No |
| Heart Arrhythmia | Yes | No |
| Stroke | Yes | No |
| Liver Disease | Yes | No |
| Hepatitis | Yes | No |
| Cirrhosis | Yes | No |
| Kidney Disease | Yes | No |
| Lung Disease | Yes | No |
| Emphysema | Yes | No |

| | | |
|---|---|---|
| Bronchitis | Yes | No |
| Asthma | Yes | No |
| Tuberculosis | Yes | No |
| Pneumonia | Yes | No |
| Gastric (Stomach) Ulcers | Yes | No |
| Colitis | Yes | No |
| Diabetes Type I or Type II | Yes | No |
| Do you take Insulin? | Yes | No |
| Thyroid Disease | Yes | No |
| Glaucoma | Yes | No |
| Bleeding Problems | Yes | No |
| Epilepsy | Yes | No |
| HIV/AIDS | Yes | No |
| Anemia | Yes | No |
| Hypoglycemia | Yes | No |

| | | |
|---|---|---|
| Sickle Cell Anemia or Trait | Yes | No |
| Tumor or Cancer | Yes | No |
| Hip/Joint Replacement/Surgery | Yes | No |
| Do you take or have you ever taken: | | |
| A. Blood Thinners | Yes | No |
| B. Cortisone (Steroids) | Yes | No |
| C. Aspirin Daily | Yes | No |
| D. Bone Density Drug | Yes | No |
| Communicable Diseases | Yes | No |
| If so, list | | |
| Sinus Problems | Yes | No |
| Women: Pregnant | Yes | No |
| If so, Due Date | | |
| | | |
| Wear Contacts | Yes | No |

**Have you ever been told you need to premedicate before dental treatment? Yes No**

Do you have any allergies? Yes or No IF SO, PLEASE LIST _____

_____

Your physician phone number _____

1. General Health _____ Good _____ Fair _____ Poor
2. Are you now or have you ever been under a physician's care during the past 5 years? Y or N Why? _____

_____

3. Have you ever had a serious illness not listed above? Y or N What? _____

_____

4. Have you had a previous surgery? Y or N Any adverse reactions? Y or N Explain _____

_____

5. What medications are you currently taking? _____

_____

6. Do you smoke or use smokeless tobacco? Y or N _____ packs/day # of years you have smoked?_____
7. Do you use alcohol? Y or N _____#of drinks/week 8. Do you use illicit drugs? Y or N
9. Date of last dental exam _____ Of pan or full series of x-rays? _____ Of last bitewing x-rays? _____
10. What are your chief dental concerns? _____
11. Do you have any tooth or teeth pain? Y or N Pressure? Y or N Cold? Y or N Hot? Y or N
    if so, where? _____
12. Gum sensitivity or pain? Y or N 13. Do you have any loose or broken fillings? Y or N
14. Any changes or sores in your soft tissues (i.e.: lips, cheeks, tongue, etc.?) Y or N
15. Is there anything you want to change about the appearance of your teeth? Y or N
    Would you like your teeth to be whiter? Y or N Are there spaces you would rather not have? Y or N
    Would you like your teeth to be straighter? Y or N
16. Do you grind your teeth? Y or N What time of day/night? _____
17. Any pain in jaw joint? Y or N Any pain in the muscles of the face? Y or N

**Do you have any dental fears/phobias or any previous problems with dental treatment? Yes No**

**If yes, explain** _____

**For Children Only:**

Did your child ever have a negative dental experience Y or N Explain: _____

Mouth habits: Thumb Sucking? Y or N Mouth breathing? Y or N

Has your child had orthodontic treatment? Y or N Orthodontist's name: _____

Does your child receive flouride? Y or N In the form of (please circle): WATER PILLS RINSE