Ash Family Dental

**Patient Registration**

Please enter the patient details:

**First Name:** _____

**Middle Name** (optional)**:** _____

**Last Name:** _____

**Preferred Name:** _____

**Birth Date:** ____/_____/_____

**SSN:** _____-____-_____

**Gender** (Circle one)**:** Male or Female

**Marital status** (Circle one)**:** Single - Divorced - Married

**Address:** _____

_____

**City:** _____

**State:** _____

**Zip Code:** _____

**Home Phone:** _____-_____-_____

**Work Phone:** _____-_____-_____ **Ext:** _____

**Cell Phone:** _____-_____-_____

**Email:** _____

**Responsible Party**

If the patient has a responsible party, please enter their details:

**First Name: _____**

**Middle Name** (optional)**: _____**

**Last Name: _____**

**Birth Date: ____/_____/_____**

**Gender** (Circle one)**:** Male or Female

**Marital status** (Circle one)**:** Single - Divorced - Married

**Address: _____**

**_____**

**City: _____**

**State: _____**

**Zip Code: _____**

**Home Phone: _____-_____-_____**

**Work Phone: _____-_____-_____ Ext: _____**

**Cell Phone: _____-_____-_____**

**Relation to Patient: _____**

**SIGNATURE:**

**X_____ DATE:_____**

# Medical History

**Please enter your medical history details:**

**Physician Name: _____**

**Physician Phone: _____-_____-_____**

**Emergency Contact: _____**

**Emergency Contact Phone: _____-_____-_____**

**Pharmacy: _____**

**Allergies:** Please circle Yes or No

Yes – No **Aspirin**

Yes – No **Codeine**

Yes – No **Dental Anesthetics**

Yes – No **Erythromycin**

Yes – No **Jewelry**

Yes – No **Latex**

Yes – No **Metals**

Yes – No **Penicillin**

Yes – No **Tetracycline**

**List any other allergies here:**

_____

_____

_____

**Conditions:** Please circle Yes or No

| | | | |
|---|---|---|---|
| Yes – No | **Alcohol Abuse** | Yes – No | **Heart Attack** |
| Yes – No | **Anemia** | Yes – No | **Heart Disease** |
| Yes – No | **Angina** | Yes – No | **Heart Surgery** |
| Yes – No | **Artificial Heart Valve** | Yes – No | **Hepatitis** |
| Yes – No | **Aspirin Daily** | Yes – No | **High Blood Pressure** |
| Yes – No | **Asthma** | Yes – No | **Hip/ Joint Replacement** |
| Yes – No | **Bleeding Problems** | Yes – No | **Hypoglycemia** |
| Yes – No | **Blood Thinners** | Yes – No | **Kidney Problems** |
| Yes – No | **Bone Density Drug** | Yes – No | **Liver Disease** |
| Yes – No | **Bronchitis** | Yes – No | **Lung Disease** |
| Yes – No | **Cirrhosis** | Yes – No | **Mental Health** |
| Yes – No | **Colitis** | Yes – No | **Neurological Disorder** |
| Yes – No | **Communicable Diseases** | Yes – No | **Other Infectious Disease** |
| Yes – No | **Diabetes** | Yes – No | **Pneumonia** |
| Yes – No | **Insulin Dependent** | Yes – No | **Seizures** |
| Yes – No | **Drug Abuse** | Yes – No | **Sickle Cell Disease** |
| Yes – No | **Eating Disorder** | Yes – No | **Sinus Problems** |
| Yes – No | **Epilepsy** | Yes – No | **Sleep Apnea** |
| Yes – No | **Fainting Spells** | Yes – No | **Stroke** |
| Yes – No | **Gastric Reflux** | Yes – No | **Thyroid Problems** |
| Yes – No | **HIV+ AIDS** | Yes – No | **Tuberculosis** |
| Yes – No | **Headaches/ Migraines** | Yes – No | **Tumor/ Cancer** |
| Yes – No | **Heart Arrhythmia** | Yes – No | **Ulcers** |

Yes – No **Do you use tobacco?**

**For Women Only:** Please Circle Yes or No

Yes – No **Birth Control**

Yes – No **Are you Pregnant?**

If so, how many weeks? **_____**

Yes – No **Nursing**

**Please list all medications, over the counter and herbal supplements that you take:**

**_____**
**_____**
**_____**
**_____**

**PATIENT SIGNATURE**

**X_____ DATE: _____**

**DENTISTS SIGNATURE**

**X_____DATE: _____**

Ash Family Dental

**Dental History Form**

Patient Name _____ Date _____

Have you ever had a serious illness not listed under the health history? Y N

Have you had previous surgery? Y N

Any adverse reactions? Y N

Any dental fears or phobias? Y N

Have you had problems associated with previous dental treatment? Y N

Do you frequently drink soda, juice or other sugary drinks? Y N

Do you have any tooth or teeth:

Pain? Y N

Pressure? Y N

Hot? Y N

Cold? Y N

Gum sensitivity or pain? Y N

Gums Bleed? Y N

Do you have any broken or loose fillings? Y N

Do you wear partials or dentures? Y N

Do you have any sores or ulcers in your mouth? Y N

Is there anything you want to change about the appearance of your teeth? Y N

| | |
|---|---|
| Would you like your teeth to be whiter? | Y N |
| Are there spaces you would rather not have? | Y N |
| Would you like your teeth to be straighter? | Y N |
| Are you unhappy with the shape of your teeth? | Y N |
| Are you unhappy with the shape or position of your gums? | Y N |
| Do you clench/grind your teeth? | Y N |
| Any noise, popping or clicking in your jaw joint? | Y N |
| Any pain in your jaw joint? | Y N |
| Any pain in face or muscles of the face? | Y N |
| Do you have earaches or neck pain? | Y N |
| Have you ever had a serious injury to your head or mouth? | Y N |
| Do you snore? | Y N |
| Have had any trouble breathing or struggle to breathe while sleeping? | Y N |
| Do you breathe through your mouth? | Y N |
| Do you experience dry mouth? | Y N |
| Do you wake feeling unrefreshed? | Y N |
| Have you had orthodontics in the past 5 years? | Y N |

**FOR CHILDREN ONLY**

| | |
|---|---|
| Did your child ever have a bad dental experience? | Y N |

**MOUTH HABITS:**

| | |
|---|---|
| Thumb sucking? | Y N |
| Bottle Nursing? | Y N |
| Does your child have a sweet tooth? | Y N |

Has your child had orthodontic treatment? Y N

Does your child receive fluoride? Y N

Patient Signature _____