Bayou City Dental, PA

PATIENT REGISTRATION

Welcome to our office! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there has been any change in your health, please tell us. If you have any questions, don't hesitate to ask.

PATIENT INFORMATION

Patient Name (FIRST, MI, LAST): _____ SS #: _____

☐ Male ☐ Female Date of Birth: _____ Age: ____ ☐ Married ☐ Single ☐ Child ☐ Other E-mail Address _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Best Time to Call: _____

In Case of Emergency, CONTACT: _____ Phone #: _____

Pt's Employer Name: _____ Occupation: _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐ Insurance ☐ Newspaper ☐ Receipt ☐ School ☐ Work ☐ Other _____

☐ Friend _____ ☐ Relative _____ ☐ Dental Office _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name (FIRST, MI, LAST): _____ DL #: _____ SS #: _____

☐ Male ☐ Female Date of Birth: _____ Age: _____ ☐ Married ☐ Single ☐ Child ☐ Other _____

Address (if different from above): _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Best Time to Call: _____

INSURANCE INFORMATION

Primary

Name of Insured (FIRST, MI, LAST): _____

Date of Birth: _____ SS #: _____ ID#: _____ Group #: _____

Address (if different from above): _____ City: _____ State: _____ Zip Code: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Insured's Employer Name: _____

Insurance Plan Name: _____ Phone #: _____

DENTAL HISTORY

Reason for Visit:_____

_____

Place a check mark in the boxes that apply:

- ☐ Sensitive Teeth
- ☐ Toothache
- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Smoking Of Any Kind
- ☐ Clicking/Popping Jaw
- ☐ Grinding/Clenching Teeth
- ☐ Loose Teeth
- ☐ Broken Fillings
- ☐ Pain Around Ear
- ☐ Jaw Pain
- ☐ Sensitivity To Cold / Heat / Sweets (Circle)
- ☐ Brush ____ Daily; Floss ____ Daily
- ☐ Have Not Been To Dentist For Awhile
- ☐ Apprehensive About Dental Treatment
- ☐ Bad Experience In Dental Office
- ☐ Dissatisfied With Shape And Size Of Teeth/Smile
- ☐ Dissatisfied With Whiteness Of Teeth

HEALTH HISTORY

Place a check mark in the boxes that apply:

(IF NONE APPLIES, PLEASE INITIAL HERE _____)

- ☐ Abnormal Bleeding
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cholesterol
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Recent Surgery On: _____

  Type: _____
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swollen Feet/Ankles/Neck Glands
- ☐ Taken Fen-Fen (diet drugs)
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Ulcer
- ☐ Under Care of Physician _____
- ☐ Venereal Disease
- ☐ Wear Contact Lens

Women

- ☐ Pregnancy Due In: _____
- ☐ Nursing
- ☐ Oral Contraceptives / Birth Control

  Name: _____

Allergies – Place a check mark in the boxes that apply:

(IF NONE APPLIES, PLEASE INITIAL HERE _____)

- ☐ Aspirin / Acetaminophen / Ibuprofen (Circle)
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine / Demerol / Other narcotics _____ (Circle)
- ☐ Iodine
- ☐ Latex or rubber
- ☐ Local Anesthetic
- ☐ Penicillin / Other antibiotics _____ (Circle)
- ☐ Reaction to metals: _____
- ☐ SulfaOther _____

Medications – List any medications currently taking:

(IF NONE, PLEASE INITIAL HERE _____)

_____

_____

_____

_____

Pharmacy

Name: _____

Phone: _____

Please Sign_____**Date**_____