The DC Dentist



509 11TH ST SE.

Washington D.C 20003

(202) 544 – 3626

www.thedcdentist.com

**Patient Registration Form**

**Patient Information Date of Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| Patient First Name: | Middle Name: | Last Name: |
| Gender: | Marital Status: | Date of Birth (Age): | Social Security # |
| Patient’s Address:  | City: | State: | Zip Code: |
| Home Phone # | Mobile Phone # | E-mail address: |
|

|  |  |  |
| --- | --- | --- |
| **Emergency Contact Name:** | Emergency Contact Phone: | Relationship to Patient: |

 Whom may we thank for referring you? |

**Patient Employer / School Information**

|  |  |  |
| --- | --- | --- |
| Employer / School: | Occupation: | Employer / School Phone: |
| Employer / School Address: | City: | State: | Zip: |

**Billing and Insurance**

|  |  |
| --- | --- |
| Insurance Company: | Plan: |
| Plan Number: | Group Number: | Subscriber Employer / School |
| Subscriber Name (As it appears on insurance card or ID): |  Relationship to patient:  |
| Subscriber Address: | Subscriber date of birth:  |
| **Secondary Insurance information**Insurance Company: | Subscriber Employer / School |
| Plan Number: | Date of Birth |
| Subscriber Name | Relationship to patient: |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Patient or Authorized Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name Date of Appointment**

**Reason for today’s visit Allergies**

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| Are you allergic to any of the following?**🞎** Local Anesthetics **🞎**  Penicillin **🞎** Latex**🞎** Aspirin **🞎** Iodine **🞎** Codeine**🞎** Sulfa Other:  |
|  |

**Dental History**

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| --- |
| Former Dentist: |
| When was your last dental exam? |
| When were your last dental x-rays taken? |
| How often do you brush? |
|  How often do you floss? |

|  |
| --- |
| Have you ever had a periodontal (gum) treatment? |
| Have you ever had orthodontic treatment? |
| Please check if any of the following conditions applies to the patient:**🞎** Bad breath **🞎** Dry Mouth **🞎** Partials **🞎** Bleeding Gums **🞎** Difficulty Chewing **🞎** Blisters on Mouth **🞎** Ear Pain **🞎** Sensitivity to Hot**🞎** Broken Fillings **🞎** Jaw Pain **🞎** Sensitivity to Sweets**🞎** Clicking Jaws **🞎** Loose teeth **🞎** Sensitivity when biting**🞎** Mouth Pain **🞎** Swollen Gums **🞎** Sensitivity to cold |

**Medical History**

|  |
| --- |
| Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had any serious illness or operations: **🞎** Yes **🞎** No If so, Please explain: |
|  Please indicate if any of the following medical conditions apply to your past or current medical history:**🞎** Anemia **🞎** Back Problems **🞎** Diabetes **🞎** Heart Problems **🞎** Lupus **🞎** Alcoholism **🞎** Blood Disease **🞎** Depression **🞎** Epilepsy **🞎** Hepatitis **🞎** Arthritis, Rheumatism **🞎** Cancer **🞎** High Blood Pressure **🞎** Migraines 🞎 Skin Disorder**🞎** Asthma **🞎** Chemotherapy **🞎** Glaucoma **🞎** Kidney Disease 🞎 Stroke**🞎** Anxiety Disorder **🞎** Chemical Dependency **🞎** Headaches **🞎** Liver Disease 🞎 Venereal Disease**🞎** HIV / AIDS **🞎** Circulatory Problems **🞎** Heart Murmur **🞎** High Cholesterol **🞎** Stomach Ulcer **🞎** Fainting **🞎** Tuberculosis Other (Please Specify):  |

 **Lifestyle Factors**

|  |  |
| --- | --- |
| Do you smoke?🞎 Yes 🞎 No # of years # Packs/ day  | **WOMEN ONLY**Are you pregnant? Are you breastfeeding?🞎 Yes 🞎 No 🞎 Yes 🞎NoAre you taking birth control pills?🞎 Yes 🞎 |
| Do you use recreational drugs?🞎 Yes 🞎 No  |
| How much alcohol do you drink per week?# drinks per week |
| How much caffeine do you drink per day? |