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**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

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

**Dental History**

|  |
| --- |
| 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 🞎No  Are 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? |