The DC Dentist
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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:	Social Security #
Patient's Address:	City:	State:	Zip Code:
Home Phone #	Mobile Phone #	E-mail address:	

How did you hear about us? _____

Emergency Contact Name:	Emergency Contact Phone:	Relationship to Patient:

Patient Employer / School Information

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

Billing and Insurance

Insurance Company/Plan:	Insurance Telephone Number:	
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

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?

WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐No

Are you taking birth control pills?
☐ Yes ☐ No