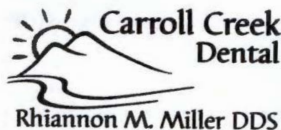


Patient Registration

Date:

Name: ________________________________

Date of Birth: _______________ Age: _______

I prefer to be called: _____________________

Legal Guardian(s): ______________________

Gender: ____ Male ____ Female

Address: ______________________________

City: __________________________________

State: ___________ Zip Code: _____________

Home Phone: __________________________

Work Phone: ___________________________

Cell Phone: ____________________________

Email: ________________________________

I would like to receive appointment reminders by:

Mail   Text Message   Email

Home Phone   Work Phone   Cell Phone

Emergency contact:

Name: __________________________

Address: ________________________

____

Phone: __________________________

Relationship; _____________________

I hereby authorize you to share my medical information with the following people:

____

It's ok to leave voicemail messages regarding my treatment: __Yes __No

Best Appointment Times: ____ AM ____ PM

__ Mon __ Tues __ Wed __Thurs __ Fri

Who may we thank for referring you?

Friend/Family ________________________

Website/Internet ______________________

Newspaper Ad ________________________

Sign _______________________________

Other ______________________________

Insurance Information:

Responsible Party: ______________________

Name of Insured: _______________________

Relationship to insured: __________________

Insurance Carrier: ______________________

Group #: _________ Policy#: ______________

Employer: ______________________________

Social Security: _________________________

General consent.

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics and other medications as necessary for the completion of my treatment. I fully understand that using anesthetic agents entails certain risks. I understand that I can ask for a complete recital of any possible complications.

Signature of Patient or Legal Guardian:

Date
____

Carroll Creek Dental
Rhiannon M. Miller DDS

Name: Date of Birth:

Physician Name and Phone Number:

Are you currently ill or have a fever? Y N

Please list all current medications. Include prescription and over the counter medications, vitamins, herbal supplements, and birth control:

Name of Medication	Dosage	Reason for Medication

Please check all conditions you have or have had at one time:

Antibiotic Allergy	Irregular Heartbeat	Joint Replacement
Penicillin Allergy	Anemia	Arthritis
Morphine Allergy	High Cholesterol	Osteoporosis
Codeine Allergy	Congenital Heart Problems	Have you ever taken osteoporosis pills? Y N
Aspirin Allergy	Heart Surgery	High or Low Thyroid
Vaccine Allergy	Angina	Diabetes
Anesthetic Allergy	Blood Transfusion	Acid Reflux
Food Allergy	COPD	Hypoglycemia
Mint Allergy	Asthma	Hepatitis
Cinnamon Allergy	Emphysema	HIV/AIDS
Toothpaste Allergy	Tuberculosis	STDs
Latex Allergy	Sleep Apnea	Glaucoma
Metal Allergy	Difficulty Breathing	Rash/Hives
Environmental Allergies	Persistent Cough	Changes in skin color
Other Allergies	Sinus Problems	Cancer
Heart Attack	Headaches	Tumor/Growth
Stroke	Fibromyalgia	Radiation or Chemotherapy
Hi/Low Blood Pressure	Epilepsy	Serious Injuries
Rheumatic Heart Disease	Anxiety/Depression	Autoimmune Disorder
Heart Murmur	Sleep Disorders	Organ Transplant
Artificial Valve	Eating Disorders	Surgeries

Please list any other conditions, medications, or symptoms not listed above:

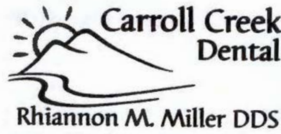
Women: Are you pregnant? Y N Due Date: Breast Feeding? Y N Birth Control Pills? Y N

Tobacco Use: I smoke Packs/Day for years I quit yrs ago I've never smoked

Cigarettes Cigars Pipe Chewing Tobacco

Alcohol Consumption: Glasses per week (Beer, Wine, Liquor) Recreational Drug Use:

Have you ever undergone treatment for chemical dependency? Y N



What is your main reason for seeking dental care? ______________________________

Yes or No

Are you currently experiencing any pain?

Are your teeth sensitive to heat, cold, sweets, or pressure?

Do you have any swelling In your mouth, face, or neck?

Are any of your teeth loose?

Are you missing any teeth?

Do you have any trouble chewing food?

Do you have any broken or chipped teeth?

Have you ever had trauma to your teeth, mouth, or face?

Have you ever had oral or throat cancer?

Do you experience frequent headaches?

Do you get canker or cold sores?

Do you grind or clench your teeth?

Do your gums bleed?

Do you have bad breath?

Do you wear any dental appliances? NIGHTGUARD

	Upper Lower Both							
Retainers:		Age of Retainers:	Removable			Bonded		
Dentures:		Age of Dentures:	At:	Good	Bad	Look:	Good	Bad
Partials:		Age of Dentures:	At:	Good	Bad	Look:	Good	Bad

How long ago was your last dental visit? Reason for visit?

How often do you: Brush your teeth times/day Floss times/day

Do you have fluoride in your drinking water? ______________

Do you have a history of frequent cavities? ______________

Do you have a history of gum disease? ______________

Are you happy with the shape of your teeth? ______________

Are you happy with the color of your teeth? ______________

Are you happy with the size of your teeth? ______________

Are you worried about the cost of quality dental care? ______________

Please select the statement that best describes how you feel about receiving dental care:

"Dental treatment doesn't make me nervous" "Just be gentle and I'll be fine"

"I get real nervous; can you prescribe me a sedative?" "The only way I'll get this work done is If I am asleep"

I attest that all the information provided regarding my overall and dental health is accurate today to the best of my knowledge. If any changes arise with my health I will inform the dentist.

Signature (Patient or Legal Guardian) Date: