PATIENT REGISTRATION

Carmichael Dental Care

Patient Name (please print):____ Date:____________
First Middle Initial Last

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Child

Date of Birth:______________ Age:___________ Social Security Number:________________________________

Home Address:____

____ Home Phone:________________________
City State Zip

Work Phone:______________________ Fax:______________________ Pager/Beeper:______________________

Cell Phone:_______________________E-mail:____

Relative Not Living With You/Relationship:____________________________________Phone:___________________

How should we contact you
to confirm appointments? ☐ Cell ☐ Home ☐ Work ☐ Text ☐ Email ☐ Other__________________________

Spouse or Responsible Party Information

Spouse or Parent (circle one):____

Person To Contact in Case of Emergency:________________________________ Phone:____________________

Person Responsible for Account:____

Address:____

Employment Information

Employer Name:____

Position Held:____ How Long: ____________________

Dental Insurance Information

PRIMARY: Name of Insured:____________________________________Insured's Date of Birth:_______________

Insured's Employer:____ Is insured a patient?_______________

Primary Dental Insurance Company:____

Address:____Phone:________________________

Contract No.:____ Group No.:__________________________

SECONDARY: Name of Insured:__________________________________Insured's Date of Birth:______________

Secondary Dental Insurance Company:____

Address:____Phone:_______________________

Contract No.:____ Group No.:__________________________

Insured's Employer:____ Is insured a patient?______________

Referral and Other Information

Have we treated other members of your family?____

How did you hear of us/who referred you? ☐ Patient or Doctor:_____________________________________

☐ Web site ☐ LinkedIn ☐ Facebook ☐ Ins. Co. ☐ Other: ____

Reason for visit:____

Is there anything special we should know?____

Health Information

1. Are you having pain or discomfort at this time?.. ☐ Yes ☐ No
2. Do you feel nervous about having dental treatment?... ☐ Yes ☐ No
3. Have you ever had a bad experience in the dental office?... ☐ Yes ☐ No
4. Have you been a patient in the hospital during the past two years?.. ☐ Yes ☐ No
5. Have you been under the care of a medical doctor during the past two years? .... ☐ Yes ☐ No
6. Physician's name and phone____
   Do you take an aspirin daily?... ☐ Yes ☐ No
7. Are you taking any medicine, drugs or pills? ☐ Yes ☐ No If yes, please list:______________________
   ____
8. Are you allergic or have you reacted adversely to any of the following medications?............. ☐ Yes ☐ No

   (If YES, please circle all that apply)

Aspirin	Nitrous Oxide	Halcion	Local Anesthetic
Darvon	Erythromycin	Keflex	
Codeine	Tetracycline	Penicillin	(Novacaine or Xylocaine)
Demerol	Percodan	Other Antibiotics	

9. Are you aware of being allergic to any other medications or substance?.................................

   If YES, please list:____ ☐ Yes ☐ No

10. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	AIDS
Heart Disease or Attack	Cough	Hepatitis A (infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Scarlet Fever	Allergies or Hives	Drug Addiction
Artificial Heart Valve	Diabetes	Hemophilia
Heart Pacemaker	Thyroid Disease	Venereal Disease(Syphilis, Gonorrhea)
Heart Surgery	X-ray or Cobalt Treatment	Epilepsy or Seizures
Artificial Joints(Hip, Knee)	Chemotherapy (Cancer, Leukemia)	Fainting or Dizzy Spells
Anemia	Arthritis	Nervousness
Stroke	Cortisone Medicine	Psychiatric Treatment
Kidney Trouble	Glaucoma	Sickle Cell Disease
Ulcers	Pain in Jaw Joints	Mitral Valve Prolapse

For Women Only: Are you pregnant? Yes ☐ ☐ No If YES, what month?________________________________

Are you taking birth control pills? Yes ☐ No ☐