ARDEN DENTAL GROUP

PATIENT REGISTRATION FORM

Patient Information

Salutation: _____ First Name: _____ Last Name:_____

Date of Birth: _____

Registering for a child? ◯ Yes ◯ No

Contact Information

Email: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact

Name: _____ Relation: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Contact Options

I prefer appointment reminders by: ☐ Phone ☐ SMS (TEXT) ☐ Email

Whom may we thank for referring you? _____

Are any other members of your family patients at our practice? ◯ Yes ◯ No

Insurance Information

Do you have Dental Insurance? ◯ Yes ◯ No

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Medical History

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by Doctor/Patient confidentiality. The Dentist will review the questions and explain any that you do not understand. Please complete the entire form.

Are you being treated for any medical condition at the present or any time within the past year?

◯ Yes ◯ No ◯ Not Sure/Maybe

When was your last medical checkup?_____

Has there been any change in your general health in the past year?

◯ Yes ◯ No ◯ Not Sure/Maybe

Are you taking any prescription, non-prescription medications, or herbal supplements?

◯ Yes ◯ No ◯ Not Sure/Maybe

Do you have any allergies?

◯ Yes ◯ No ◯ Not Sure/Maybe

Have you ever had a peculiar or adverse reaction to any medicines or injections?

◯ Yes ◯ No ◯ Not Sure/Maybe

Do you have or have you ever had asthma?

◯ Yes ◯ No ◯ Not Sure/Maybe

Do you have or have you ever had any heart or blood pressure problems?

◯ Yes ◯ No ◯ Not Sure/Maybe

Do you have or have you ever had an artificial heart valve, infection of the heart (i.e. #infective endocarditis), a heart condition from birth (i.e. congenital heart disease), or a heart transplant?

◯ Yes ◯ No ◯ Not Sure/Maybe

Do you have a prosthetic or artificial joint?

◯ Yes ◯ No ◯ Not Sure/Maybe

Do you have any conditions which may affect your immune system (i.e. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)?

◯ Yes ◯ No ◯ Not Sure/Maybe

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Have you ever had hepatitis, jaundice, or liver disease?

◯ Yes ◯ No ◯ Not Sure/Maybe

Do you have a bleeding problem or bleeding disorder?

◯ Yes ◯ No ◯ Not Sure/Maybe

Have you ever been hospitalized for any illnesses or operations?

◯ Yes ◯ No ◯ Not Sure/Maybe

Do you have, or have ever had any of the following? Please check

☐ Chest pain/angina	☐ Osteoporosis Medications	☐ Mitral Valve Prolapse	☐ Shortness of Breath
☐ Rheumatic Fever	☐ Heart Attack	☐ Stroke	☐ Cancer
☐ Pacemaker	☐ Lung Disease	☐ Heart Murmur	☐ Arthritis
☐ Steroid Therapy	☐ Diabetes	☐ Tuberculosis	☐ Drug/Alcohol Dependency
☐ Seizures	☐ Thyroid Disease	☐ Stomach Ulcers	☐ Kidney Disease

☐ None of the above

Are there any conditions/diseases not listed that you have or have had?

◯ Yes ◯ No ◯ Not Sure/Maybe

Are there any diseases/medical problems that run in your family (e.g. diabetes, cancer, heart disease, etc.)?

◯ Yes ◯ No ◯ Not Sure/Maybe

Do you smoke or chew tobacco products?

◯ Yes ◯ No ◯ Not Sure/Maybe

Are you nervous during dental treatment?

◯ Yes ◯ No ◯ Not Sure/Maybe

For women only: Are you pregnant or breastfeeding?

◯ Yes ◯ No ◯ Not Sure/Maybe

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Dental History

Do you have any specific dental concerns? Please list:

When was your last dental appointment? _____

How often do you see the dentist?

☐ Every 3 months ☐ Every 4 months ☐ Every 6 months

☐ Only when something is bothering me ☐ Not Applicable

Is there anything about the appearance of your teeth that you would like to change?

Have you ever whitened (bleached) your teeth?

◯ Yes ◯ No ◯ Not Sure/Maybe

Do you feel uncomfortable or self-conscious about the appearance of your teeth?

_____

Have you been disappointed with the appearance of previous dental work?

_____

Signature

☐ I agree to receive emails with related information and updates.

Patient / Guardian Signature: _____ Date:_____