Patient Registration

Date ______________

Home ______________
Work ______________
Cell ______________
Email ______________

Patient Name ______________ Birth Date ______________ S/S# ______________
Address ______________ City ______________ State ______ Zip ______
Employer ______________
Parent/Partner/Spouse/Significant other Name ______________ Phone ______________
Address if different than above ______________ City ______________ State ______ Zip ______
Employer ______________ Phone # ______________
Information of person responsibile for billing if other than above
Name ______________ Address ______________ Phone ______________

College Student School and Address ______________ FT/PT

Primary Insurance		Secondary Insurance	
Insured's Name ______	DOB ______	Insured's Name ______	DOB ______
ID# ______	Grp # ______	ID# ______	Grp # ______
Ins. Co. ______	Grp# ______	Ins. Co. ______	Grp# ______

DENTAL HISTORY Indicate any areas that pertain to you [X]

evious Dentist ______________ City ______________ State ______ Phone ______________

Last Dental Visit ______________ Last Hygiene Visit ______________ Date last x-rays ______________

____ Teeth sensitive to cold, heat, sweets and pressure
____ Bleeding gums
____ Food impaction
____ Clenching or grinding
____ Burning of tongue
____ Swelling or lumps in mouth
____ Frequent blisters on lips or mouth
____ Pain around ear
____ Unusual sounds in ear while eating

____ Bad Breath/Unpleasant taste
____ Missing teeth
____ Unfavorable dental experience
____ Complications from extractions
____ Periodontal (gum) treatment
____ Orthodontic treatment (braces)
____ Mouth breathing
____ Oral habits (i.e. fingernail biting)
____ Tobacco use

Previous Drug use ______________
Type of toothbrush ______________
Frequency of brushing ______________
Frequency of flossing ______________

MEDICAL HISTORY indicate any areas that pertain to you [X]

Current Physician ______________ City ______________ State ______ Phone ______________

Specialist Physician ______________ City ______________ State ______ Phone ______________

____ Heart Trouble
____ Heart Attack
____ High Cholesterol
____ Angina
____ Stroke
____ Rheumatic Fever
____ Heart Murmur
____ Mitral Valve Prolapse
____ Heart Defects
____ Pacemaker
____ Prosthetic Valves
____ Shunts
____ Surgery

____ Artificial Joints
Specify ______________
____ High Blood pressure
____ Fainting or Dizziness
____ Epliepsy
____ Seizures
____ Blood Disorders (Anemia)
____ Abnormal Bleeding
____ Tumors or Cancers
____ Radiation Treatment
____ Chemotherapy
____ Diabetes
____ Thyroid Problems

____ Hepatitis or Liver Disease
____ Kidney Trouble
____ Stomach Ulcers
____ Arthritis
____ Allergy
____ Asthma
____ Lung or Respiratory Problems
____ Glaucoma
____ Tuberculosis
____ Immune Systems Problems
____ Herpes
____ Venereal Disease
____ AIDS or HIV

____ Mental Health Problems
____ Nervous Problems
____ Allergic Reactions:
____ Anesthetics (Novocaine)
____ Antibiotics ______
____ Aspirin
____ Codeine
____ Latex
____ Other ______________
____ Months Pregnant
____ Nursing
____ Birth Control Pills
____ Other ______________

OTHER Explain: ______________

There are many medical situations which can effect or be effected by the procedures of drugs used in dentistry. Please fill out the following carefully and accurately for your safety. List all current medications both prescription and non-prescription and the dosage.

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

Emergency Contact ______________ Phone ______________ Cell Phone ______________

I have read and understand that my information is provided so that the dentist and staff can care for my needs properly. I will not hold the dentist or staff responsible for any error or omission that I have made to this form. I hereby authorize all insurance payments to be made directly to Dr. Tina Gage and that my responsibility for fee for service will be made in timely payments agreed upon by both parties.
Without 24 hour notice a cancellation fee is applied for your missed reserved appointment.

______________________________ ______________
Patient Signature Date