PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name _____ Preferred Name _____ Date _____

Address _____ City _____ State / Prov. _____ Zip / P.C. _____

E-Mail _____ Cell Phone _____ Home Phone _____

SS# / SIN _____ Birthdate _____

Sex: ☐ MALE ☐ FEMALE Gender You Identify As: _____

Check Appropriate Box: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

If College Student, F.T. / P.T., Name of School _____ City _____ State / Prov. _____

Patient's or Parent's / Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State / Prov. _____ Zip / P.C. _____

Spouse or Parent's / Guardian's Name _____

Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of an Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Phone _____ SS# / SIN _____ Employer _____

Is this Person Currently a Patient in Our Office? ☐ YES ☐ NO

INSURANCE INFORMATION

We can only file if we have updated information. Please provide the reception desk with name of insured, relationship to patient, and insurance card if available. We'll need SSN of the policy holder and or policy #.

This form gives us permission to contact the policy holder. If you do not have the information on hand, provide information here:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# / SIN _____ Date Employed _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State / Prov. _____ Zip / P.C. _____

Insurance Company _____ Tel. Number _____

GRP # _____ Policy / I.D. # _____

Insurance Co. Address _____ City _____ State / Prov. _____ Zip / P.C. _____

By signing this form, you are stating that you have reviewed and agree to the financial and reservation policy provided to you by our office.

X _____

Signature of Patient or Parent Guardian If Minor

2800 Niles Road, Saint Joseph, Michigan 49085
Tel: 269-429-2511 | Fax: 269-429-5130 | info@smilesonniles.com | www.smilesonniles.com

PATIENT'S DENTAL & MEDICAL HISTORY

Patient Name _____ Birth Date _____ Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

DENTAL HISTORY

Reason for this visit: _____

When was your last dental visit? _____

What was done? _____

Previous Dentist (Name & Location) _____

Have you had a complete series of dental films (x-rays) taken? ☐ YES ☐ NO

If yes, when/where? _____

How often do you brush your teeth? _____ How often do you floss? _____

Is your drinking water fluoridated? ☐ YES ☐ NO

Do your gums bleed while brushing or flossing? ☐ YES ☐ NO

Are your teeth sensitive to hot or cold liquids/foods? ☐ YES ☐ NO

Are your teeth sensitive to sweet or sour liquids/foods? ☐ YES ☐ NO

Do you feel pain to any of your teeth? ☐ YES ☐ NO

Do you have any sores or lumps in or near your mouth? ☐ YES ☐ NO

Do you have any of these habits?

☐ Thumb sucking ☐ Nail biting ☐ Cheek/lip biting ☐ Chewing on ice/foreign objects ☐ None

Have you noticed any loosening of your teeth? ☐ YES ☐ NO

Does food tend to become caught between your teeth? ☐ YES ☐ NO

Have you ever had periodontal treatment (gums)? ☐ YES ☐ NO

Have you ever had any difficult extractions in the past? ☐ YES ☐ NO

Have you ever had any prolonged bleeding following extractions? ☐ YES ☐ NO

Do/did your parents have dentures? ☐ YES ☐ NO

If you could change anything about your smile, what would you change? _____

_____

Have you had any head, neck, or jaw injuries? ☐ YES ☐ NO If yes: _____

Have you ever experienced any of the following problems with your jaw?

☐ Clicking ☐ Pain (Joint, Ear, Side of Face) ☐ Difficulty in opening or closing ☐ Difficulty in chewing ☐ None

Do you have frequent headaches? ☐ YES ☐ NO

Do you have any of these sleep patterns or conditions:

☐ Sleep apnea ☐ Snoring ☐ Daytime Drowsiness ☐ Bed Wetting (for children) ☐ None

Do you clench or grind your teeth? ☐ YES ☐ NO

Have you ever worn a bite plate or other appliance? ☐ YES ☐ NO

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MEDICAL HISTORY

Are you in good health? ☐ YES ☐ NO

Date of your last physical exam: _____

Are you now under the care of a physician? If yes, please list Physician's Name ☐ YES ☐ NO

If yes: _____

Have you ever been hospitalized or had a major operation? ☐ YES ☐ NO

If yes, list here: _____

Are you taking any medications, pills, or drugs? ☐ YES ☐ NO If yes, please fill out medication list separately.

Have you had any abnormal bleeding? ☐ YES ☐ NO

If yes, explain further: _____

Do you bruise easily? ☐ YES ☐ NO

Have you ever required a blood transfusion? ☐ YES ☐ NO

Have you had a recent weight loss? ☐ YES ☐ NO

Do you take, or have you taken Phen-Fen or Redux? ☐ YES ☐ NO

If yes, currently or how many years ago?: _____

***The following three questions are incredibly important for the dentist to know.**

*Do you take blood thinners, Warfarin, such as Coumadin, Xarelto? ☐ YES ☐ NO

*Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates? ☐ YES ☐ NO

If yes, which one? _____ How often? _____ For how long? _____

*Have you ever been prescribed antibiotic pre-medication for dental treatment? ☐ YES ☐ NO

If yes, what medication? _____

Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? ☐ YES ☐ NO

Do you use tobacco? ☐ YES ☐ NO If yes, ☐ Cigarettes ☐ Cigar ☐ Chewing Tobacco ☐ Vape

Do you use marijuana? ☐ YES ☐ NO If yes, in what capacity? _____

Do you or have you used controlled substances? ☐ YES ☐ NO

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO If yes, how many weeks? _____

Are you nursing? ☐ YES ☐ NO

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metals (Nickel, Mercury) ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics like Novocaine

☐ Barbiturates, Sedatives, or Sleeping Pill ☐ Iodine

☐ Other If yes: _____

Have you been fully vaccinated for COVID -19? ☐ YES ☐ NO

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REVIEW OF SYSTEMS

Do you have or have you ever had the following medical conditions:

Aids or HIV Infection	☐ YES ☐ NO	Cortisone Medicine	☐ YES ☐ NO	Hepatitis A	☐ YES ☐ NO	Radiation Treatments	☐ YES ☐ NO
Alzheimer's Disease	☐ YES ☐ NO	Diabetes	☐ YES ☐ NO	Renal Dialysis	☐ YES ☐ NO	Anaphylaxis	☐ YES ☐ NO
Drug Addiction	☐ YES ☐ NO	Hepatitis B or C	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO	Anemia	☐ YES ☐ NO
Easily Winded	☐ YES ☐ NO	Herpes	☐ YES ☐ NO	Rheumatism	☐ YES ☐ NO	Angina	☐ YES ☐ NO
Emphysema	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Scarlett Fever	☐ YES ☐ NO	Arthritis/ Gout	☐ YES ☐ NO
Epilepsy or Seizures	☐ YES ☐ NO	High Cholesterol	☐ YES ☐ NO	Shingles	☐ YES ☐ NO	Artificial Heart Valve	☐ YES ☐ NO
Excessive Bleeding	☐ YES ☐ NO	Hives or Rash	☐ YES ☐ NO	Sickle Cell Disease	☐ YES ☐ NO	Asthma	☐ YES ☐ NO
Excessive Thirst	☐ YES ☐ NO	Hypoglycemia	☐ YES ☐ NO	Sinus Trouble	☐ YES ☐ NO	Blood Disease	☐ YES ☐ NO
Fainting Spells/ Dizziness	☐ YES ☐ NO	Irregular Heartbeat	☐ YES ☐ NO	Spina Bifida	☐ YES ☐ NO	Frequent Diarrhea	☐ YES ☐ NO
Frequent Cough	☐ YES ☐ NO	Kidney Problems	☐ YES ☐ NO	Breathing Problems	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO
Leukemia	☐ YES ☐ NO	Stomach/ Intestinal Disease	☐ YES ☐ NO	Low Blood Pressure	☐ YES ☐ NO	Swelling of Limbs	☐ YES ☐ NO
Stroke	☐ YES ☐ NO	Genital Herpes	☐ YES ☐ NO	Lung Disease	☐ YES ☐ NO	Thyroid Disease	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO	Tonsillitis	☐ YES ☐ NO
Chemotherapy	☐ YES ☐ NO	Hay Fever	☐ YES ☐ NO	Osteoporosis	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Chest Pains	☐ YES ☐ NO	Heart Attack / Failure	☐ YES ☐ NO	Pain in Jaw Joints	☐ YES ☐ NO	Tumors or Growths	☐ YES ☐ NO
Cold Sores/ Fever Blisters	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO	Parathyroid Disease	☐ YES ☐ NO	Ulcers	☐ YES ☐ NO
Congenital Heart Disorder	☐ YES ☐ NO	Heart Pacemaker	☐ YES ☐ NO	Psychiatric Care	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO
Convulsions	☐ YES ☐ NO	Heart Trouble/ Disease	☐ YES ☐ NO	Artificial Joint	☐ YES ☐ NO	Hemophilia	☐ YES ☐ NO
Yellow Jaundice	☐ YES ☐ NO	Back Problem/ Surgery	☐ YES ☐ NO	GERD/Acid Reflux	☐ YES ☐ NO		

If yes to any of the above, please see next page to elaborate.

History of an eating disorder? ☐ YES ☐ NO If yes: _____

Do you have any disease, condition or problem not listed above? ☐ YES ☐ NO

If yes: _____

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PHARMACY

What is the name of your local pharmacy? _____

COMMENTS

If needed, please use this space to elaborate any condition you answered yes to under Review of Systems. For example, "Breast cancer in 2005, now in remission."

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I am consenting to all treatment provided by and agreed upon between myself and my dental providers.

X _____

Signature of Patient or Parent Guardian If Minor

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PATIENT MEDICATION LIST

This is often the most important part of the medical history, please be as thorough as possible.

Name: _____ Today's Date: _____

In order to fill out the form, you need a list of all of your medicines or everything you take in front of you. Be sure you include medicine you take from all pharmacies that you use as well as any over-the-counter medicines, vitamins, herbs or minerals you may take. For every medicine (including ones you get without a prescription), vitamin or herb you take, please write down these things:

- Medication – The name of what you take (like Tylenol, Acetaminophen 500 mg)
- Dosage – How much you take of this (like 1 pill of 150 mg)
- Times/Day – How often you take the medication (like once, twice, three)
- Comments – Add any additional information such as why you take the medication

Medication	Dosage	Times/Day	Comments

Pharmacy: _____

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