

The South Texas Center for Cosmetic Dentistry

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Registration Form

Name: Last _____ First _____ MI _____ Birth date _____ Age _____
 Soc. Sec. # _____ Sex: M F Email address _____
 Today's Date _____ How did you hear about us? _____
 Street Address _____ Apt. # _____ City _____ State _____ ZIP _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Previous Address (if less than 3 yrs.) Street _____ Apt. # _____ City _____ State _____ ZIP _____
 Employer _____ Occupation _____ # Years Employed _____
 Work Address _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____
 Insurance Co. _____
 Address _____ Phone _____
 Insured's Employer _____
 Insured's SSN _____ Group # _____

Dental Insurance Information (Secondary Carrier)

Insured's Name _____
 Insurance Co. _____
 Address _____ Phone _____
 Insured's Employer _____
 Insured's SSN _____ Group # _____

Do you have any current health problems? Yes No
 Are you under a physician's care now? Yes No
 For what? _____
 Are you pregnant? Yes No
 Are you allergic to or have you reacted adversely to (circle):
 Aspirin Local anesthetic Erythromycin Latex
 Tetracycline Codeine Penicillin Ibuprofen
 Are you aware of being allergic to any other substances? Yes No
 If yes, please list: _____

 What medications are you currently taking? _____

 List any other medical information we should know about _____

 Family Physician _____ Phone _____

Please circle any of the following which you have had or presently have:

- | | | |
|--------------------------|-----------------------|---------------------|
| Heart disease or attack | AIDS/HIV Pos | Bruise Easily |
| Angina Pectoris | Hepatitis A | Emphysema |
| High Blood Pressure | Hepatitis B | Tuberculosis (TB) |
| Heart Murmur | Hepatitis C | Asthma |
| Rheumatic Fever | Liver Disease | Hay Fever |
| Congenital Heart Lesions | Blood Transfusion | Sinus Trouble |
| Mitral Valve Prolapse | Drug Addiction | Allergies or Hives |
| Artificial Heart Valve | Bleeding Problems | Diabetes |
| Heart Pacemaker | Fever Blisters | Thyroid disease |
| Heart Surgery | Epilepsy or Seizures | Radiation Treatment |
| Artificial Joints | Nervousness | Arthritis |
| Anemia | Psychiatric Treatment | Steroid Medication |
| Stroke | Glaucoma | Chronic Depression |
| Kidney Problems | Chemotherapy | Alcoholism |
| Ulcers | Venereal Disease | Cosmetic Surgery |

Dental History

What brings you to our office? _____

How long since you have seen a dentist? _____ Reason for that visit? _____

Date of last complete dental exam. _____ Date of last complete set of x-rays _____

Please answer the following:

Are you having any problems now? Yes No

If so, what? _____

Is your present dental health good?	Yes	No	Do you have ear congestion?	Yes	No
Are you apprehensive about dental treatment?	Yes	No	Does food tend to get caught between your teeth?	Yes	No
Have you ever had periodontal (gum) treatments?	Yes	No	Have you had braces in the past?	Yes	No
Do your gums bleed or feel tender or irritated?	Yes	No	Have you noticed your teeth shifting?	Yes	No
Are your teeth sensitive to hot or cold?	Yes	No	Has there been any change in your bite?	Yes	No
Are your teeth sensitive to pressure?	Yes	No	Do you have any loose teeth?	Yes	No
Are you unhappy with the appearance of your teeth?	Yes	No	Is there any clicking or popping in your jaw joints?	Yes	No
How often do you have headaches? Daily Weekly Monthly Never	Yes	No	Are you aware of grinding or clenching your teeth?	Yes	No
Do you know the cause?	Yes	No	Do you have neck pain or stiffness?	Yes	No
The cause is _____			Do you suffer from episodes of vertigo?	Yes	No

How would you improve your smile? _____

How do you feel about your teeth? _____

What would be the ideal thing we could do for you? _____

So that we better understand what you want from us, please circle your choices:

How healthy do you want your mouth to be?

The best it can be

Average

Don't really care

At what point do you want to call a problem a problem?

When not ideal

When something is worsening

When hurts or breaks

What quality of dentistry do you want us to recommend?

Ideal

Average

"Just patch it"

Name of previous dentist _____ City _____ State _____

I consent to the taking of photographs and X-Rays before, during and after treatment, and their use in scientific papers, demonstrations, or marketing.

Patient Signature _____

Date _____

Thank you for coming. You will find we are different from any dental office you have ever been to. We promise to do our best to help you. We look forward to that opportunity.