



REGISTRATION DATA

PLEASE PRINT

Patient Name _____ Last _____ First _____	Sex: Male _____ Female _____
Spouse's Name _____ Last _____ First _____	Birthday _____
Address _____ _____	Married _____ Single _____ Divorced _____
City _____ State _____ Zip Code _____	SS # _____
Parent/Guardian _____ Last _____ First _____	Home Telephone No. _____
Employer _____	Work _____
Address _____ _____	Who Referred You: _____
E-Mail Address _____	_____

Method of Payment (Please Check One)

_____ Patient (or Parent/Guardian) will be personally responsible for the payment of the account.

_____ Patient is covered by dental insurance* Access/Med Plus _____ Recipient # _____

*In the case of divorced or separated parents, our office policy is the parent who requests treatment for the child is responsible for all fees for services.

INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

Insurance Address: _____

Insurance Address: _____

Name of Policyholder: _____

Name of Policyholder: _____

Identification #: _____

Identification #: _____

Group #: _____

Group #: _____

Relationship to Insured:
 Self Spouse Child Other _____

Relationship to Insured:
 Self Spouse Child Other _____

***Please note that the patient is responsible for the payment of charges not covered by insurance.**

Person to contact in case of office emergency Name _____
Last _____ First _____
Telephone No. _____

I hereby authorize the Plaza Dental Associates to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Signature _____ Date _____ Relationship _____
 _____ Adult Patient
 _____ Parent
 _____ Guardian

~ Please see other side ~

MEDICAL HISTORY

Please check Yes or No to the following:

Yes	No		Yes	No	Yes	No	Allergic to:	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia/Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure/High	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure/Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/X-Ray Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever taken the drug Fen-Phen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease (heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Do you have Thyroid Disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

My Medical Doctor is _____ When last visited? _____

Taking Medications? Yes No List Medications _____

p
Any Prior Unpleasant Dental Treatment? _____

Patient's (or Parent's) signature _____

DENTAL HISTORY

When was the last time you were under regular dental care? _____

How long since you have been to a dentist? _____ Are you having any discomfort? _____

If so, what is the discomfort? _____

Are you aware of any swelling or lump in your mouth? _____ Do your gums bleed? _____

Are you sensitive to cold? _____ To heat? _____ To sweets? _____

Do you grind or clench your teeth? _____ Do you snore? _____

Have you or has anyone else in your immediate family been a patient here before? _____ If so, how long ago? _____

Are you happy with the appearance of your teeth? _____

MEDICAL HISTORY UPDATE

OFFICE USE ONLY

Review of Health History by Dr. _____ Date _____

Remarks _____

Medical Update by Dr. _____ Date _____

Changes in Medical Condition? YES NO Changes in Medication? YES NO

Medical Update by Dr. _____ Date _____

Changes in Medical Condition? YES NO Changes in Medication? YES NO

Medical Update by Dr. _____ Date _____

Changes in Medical Condition? YES NO Changes in Medication? YES NO

Medical Update by Dr. _____ Date _____

Changes in Medical Condition? YES NO Changes in Medication? YES NO