# Eagle River Smiles
# WELCOME!!!

**REGISTRATION FORM**

**Section I: Patient Information Date_____**

Name: _____ I prefer to be called: _____
Address: _____City:_____State:_____Zip_____
Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
The best time to contact me is: _____ ☐ A.M. ☐ P.M. On my ☐ Home ☐ Work ☐ Cell ☐ Email
Date of Birth: _____ Social Security Number: _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name_____ Employer_____ Work Phone_____

**Whom may we thank for referring you?** _____
Person to contact in case of emergency_____ Phone_____
Email Address_____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

**Section II Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name_____ Relationship to Patient: _____
Address_____
City_____ State_____ Zip_____ Phone (____) _____
Employer_____ Work Phone (____) _____ SSN#_____

**Section III Insurance Information**

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer: _____City_____State_____Zip _____
Insurance Company: _____ Group #_____ ID#_____
Ins Co Address: _____ INS Co. Phone: _____

********** DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING *********

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer: _____ Work Phone: (____) _____
Address of Employer_____City_____State_____Zip _____
Insurance Company_____ Group #_____ ID#_____
Ins Co Address: _____ INS Co. Phone: _____

**Have you ever had any of the following?**
**Please check those that apply:**

**PATIENT NAME:** _____

- □ AIDS or HIV infection
- □ Anemia
- □ Angina
- □ Arthritis
- □ Artificial Joints _____date
- □ Asthma
- □ Blood Disease
- □ Cancer /Leukemia
- □ Chest Pain
- □ Diabetes
- □ Dizziness
- □ Emphysema
- □ Epilepsy
- □ Excessive Bleeding
- □ Fainting/Seizures
- □ Glaucoma
- □ Hay Fever/Allergies
- □ Heart Attack
- □ Heart Disease
- □ Heart Murmur
- □ Hepatitis*/Jaundice
- □ *Circle: A B or C
- □ High Blood Pressure
- □ Kidney Disease
- □ Liver Disease
- □ Mental Disorders
- □ Mitral Valve Prolapse
- □ Nervous Disorders
- □ Pacemaker
- □ Radiation Treatment
- □ Recent Weight Loss
- □ Respiratory Problems
- □ Rheumatic Fever
- □ Rheumatism
- □ Sinus Problems
- □ Snoring or sleep apnea
- □ Stomach Problems/Ulcers
- □ Stroke
- □ Thyroid Problems
- □ Tuberculosis
- □ Tumors
- □ Winded Easily
- □ Venereal Disease

**Drug Allergies:**

- □ Codeine Allergy
- □ Penicillin Allergy
- □ Local Anesthetics
- □ Sulfa drugs
- □ Sedatives
- □ Aspirin
- □ Any Metals (e.g. nickel)
- □ Latex Rubber
- □ Other_____

**MEDICATION** (s) Please list any medication(s), dose and reason for taking them _____

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How long has it been since your last dental cleaning? _____ Have you ever been treated by a periodontist (gum specialist)? □ 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

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

- □ Clicking
- □ Difficulty in opening or closing
- □ Pain (Joint, Ear, Side Face)
- □ Difficulty in chewing

Do you have frequent headaches? □ Yes □ No

Do you clench or grind your teeth? □ Yes □ No

Do you bite your lips or cheeks frequently? □ Yes □ No

Have you ever had any difficult extractions in the past? □ Yes □ No

Have you ever had prolonged bleeding following extractions? □ Yes □ No

Have you ever had orthodontic work? □ Yes □ No

Does the dental office make you anxious or nervous? □ Yes □ No

Have you been hospitalized within the last five years? □ Yes □ No

Do you like your smile? □ Yes □ No If NO, please explain_____

Would you like more information on straightening your teeth □ Yes □ No **OR** Whitening your teeth □Yes □ No

Do you wear dentures or partials? □ Yes (Date of placement) _____ □ No

Are you happy with your dentures? □ Yes □ No (Please Explain) _____

Do you use tobacco? Pack per day? ____ Years? _____ Do you chew tobacco? Years? _____ □ Yes □ No

Are you wearing contact lenses? □ Yes □ No Have you ever had oral hygiene instructions? □ Ye s □ No

- If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information to third party payers and /or health practitioners.

_____ Date: _____

**Signature of patient, parent or guardian**