SQUAN FAMILY DENTISTRY

54 Broad Street
Manasquan, NJ 08736
732.223.8833

REGISTRATION FORM

PATIENT'S NAME: _____(Child/Adult)
DATE:_____

NICKNAME:_____PREFERRED TITLE:__MR__MRS__MISS__MS__DR__OTHER

DATE OF BIRTH:_____ AGE:_____ SEX:__M__F

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____ WORK PHONE:_____

CELL:_____ EMAIL:_____

Please check above the best number to reach you at during the day

EMPLOYER:_____(May we call you at work?)_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

SOCIAL SECURITY NUMBER (Patient's):_____

MARITAL STATUS:_____NAME OF SPOUSE OR PARENTS:_____

OF CHILDREN___ FIRST NAMES AND AGES:_____

NAME OF RESPONSIBLE PARTY:_____

IN CASE OF EMERGENCY, CONTACT:_____PHONE:_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

INSURANCE: (Y / N) SECONDARY COVERAGE: (Y / N)
IF FULL TIME STUDENT, SCHOOL & CITY:_____

NAME OF PERSON PROVIDING PRIMARY INSURANCE:

_____ SS#:_____DATE OF BIRTH:____/____/____

EMPLOYER PROVIDING INSURANCE:_____

INSURANCE COMPANY:_____GROUP ID #:_____

NAME OF PERSON PROVIDING SECONDARY INS.:

_____ SS#:_____DATE OF BIRTH:____/____/____

EMPLOYER PROVIDING SECONDARY INSURANCE:_____

INSURANCE COMPANY:_____GROUP ID#:_____

MEDICAL / DENTAL INFORMATION

Chief Dental Complaint (Why are you here?)_____

When was the last time you went to the dentist?_____

Why did you leave your dentist?_____

What did you like about your last dentist?_____

Have you ever had any of the following? *(Check all that apply)*

- ☐Heart Problems
- ☐High Blood Pressure
- ☐Low Blood Pressure
- ☐Circulatory Problems
- ☐Nervous Problems
- ☐Radiation Treatment
- ☐Artificial Heart Valves or Joints
- ☐Recent Weight Loss
- ☐Back Problems
- ☐Diabetes
- ☐Respiratory Disease
- ☐Asthma
- ☐Epilepsy
- ☐Hepatitis, Jaundice or Liver Disease
- ☐Cancer
- ☐Psychiatric Care
- ☐Chronic Diarrhea
- ☐Allergies to 'novacaine'
- ☐Allergies to Medicine or Drugs
- ☐General Allergies
- ☐Blood Disease
- ☐Arthritis
- ☐Cardiac Pacemaker
- ☐Special Diet
- ☐Swollen Neck Glands
- ☐Rheumatic Fever
- ☐Sinus Problems
- ☐'A.I.D.S.' or Other
- ☐Stroke
- ☐Ulcer
- ☐Venereal Disease
- ☐Chemical Dependency
- ☐Hemophilia
- ☐Tuberculosis
- ☐Clicking, Popping or Jaw Joint Sounds
- ☐Habitual Clenching or Grinding of Teeth
- ☐Headaches, Ear Pain, Neckaches, Backaches
- ☐Bleeding Gums
- ☐Thyroid Problems

Explain all checked boxes:_____

_____

Have you ever had an adverse reaction to any medication?_____ If so, what?_____

Do you need to pre-medicate with antibiotics due to heart valve or joint replacement?_____

Have you had cankers or cold sores in your tongue, gums or body?_____

Have you ever responded adversely to medical or dental treatment?_____

Are you taking any medication at this time? _____If so, what?_____

Are you under the care of a physician ☐ Yes ☐ No Name_____

For what conditions?_____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history?_____

_____

Cosmetic Questions:

How would you rate your smile on a scale of 1 – 10?_____

Do you like your smile?_____

Would you like your teeth straighter?_____

Would you like your teeth whiter?_____

Do you tend to hide your teeth when you smile?_____

Are you happy with the shape of your teeth?_____

Would you be interested in straightening your teeth with invisible braces?_____

Do you want a smile evaluation?_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____ Date_____