MOORESTOWN DENTAL PROFESSIONALS,PC
PATIENT REGISTRATION

Welcome to Moorestown Dental Professionals. So that we may provide you with the best care possible, please complete both pages of this medical/dental history. Thank you for answering the following questions.

Name _____ _____
(Last) (First) (M.I.) (Preferred Name)
Address: _____ City/State_____ Zip code _____
Phone: (Home)_____(Work) _____(Cell) _____
Best Number and Time to reach you: _____ Email: _____
Gender: □ M □ F Date of Birth: _____ SS#:_____-____-_____
□ Minor □ Single □ Married □ Widowed □ Separated □ Divorced
If Student, name of School/College: _____ □ F/T □ P/T
Employer: _____ Do you have DENTAL INSURANCE: □ YES □ NO
Spouse/ Parent name (if minor) _____
How did you hear about us? _____

MEDICAL HISTORY

Name & Address of Physician:_____
Physician's Phone Number: _____ Date of last Physical:_____
Have you been under a physician's care during the last 2 years? □ Yes □No
Reason: _____
Have you been treated in a hospital in the last 5 years? □Yes □ No
Reason: _____
History of tobacco use? □ Yes □ No How many years? _____
Are you wearing contact lenses? □ Yes □ No
For Women : □ Pregnant/ Chance of Pregnancy If yes, what week?_____ □ Nursing □ Oral Contraceptives/Patch
Are you allergic to?

□ Aspirin □ Penicillin/Other Antibiotics □ Codeine
□ Acrylic □ Jewelry/Nickel □ Latex
□ Local Anesthetics □ Red Dye □ Other : _____

Do you now have or have you ever had any of the following? Please check the appropriate boxes.

- ❑ Abnormal Bleeding
- ❑ Alcohol/Drug Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina/Chest Pain
- ❑ Arthritis/Gout
- ❑ Artificial Bones/Joints
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Pressure
- ❑ Blood Transfusion
- ❑ Cancer/Chemotherapy
- ❑ Cold Sore/Fever Blister
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Cosmetic Surgery
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting Spells
- ❑ Frequent Headache
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Mitral Valve Prolapse
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis(A,B,orC)/ Jaundice
- ❑ HIV/AIDS
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Organ Transplant
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Venereal Disease

Have you had any disease, condition, or problem not listed? □ Yes □ No
If yes, please explain: _____

Current Medications	***Reason***
_____	_____
_____	_____
_____	_____
_____	_____

DENTAL HISTORY

Date of: Last Dental Visit _____ Last Dental Cleaning _____Last Full Mouth X-Rays_____
What was done at your last dental visit? _____
Previous Dentist's Name & Address: _____
_____
_____
Telephone: _____

How often do you have dental examinations?_____
How often do you brush?_____ Floss?_____
What other dental aids do you use (*mouthwash, water pick, fluoride*)? _____
Do you have any dental problems now? □ Yes □ No
If so, please list _____
Do you feel nervous about having dental treatment? □ Yes □ No
If so, what is your biggest concern?_____
Have you ever had an upsetting dental experience? □ Yes □ No
If so, please describe_____
Are your teeth sensitive to: □ Hot □ Cold □ Sweets □ Biting/Chewing

Do your gums bleed and/or hurt?	□ Yes	□ No
Have your parents experienced gum disease?	□ Yes	□ No
Have you noticed any loose teeth or changes in your bite?	□ Yes	□ No
Does food tend to get stuck in between your teeth?	□ Yes	□ No
Have you noticed any mouth odors or bad taste?	□ Yes	□ No

Do you?
□ Clench/grind your teeth (awake or asleep)
□ Have tired jaws, especially in the AM?
□ Bite your lips or cheeks regularly?
□ Mouth-breathe while awake or asleep?
□ Chew on foreign objects (pencils, nails, etc.)

Have you experienced?
□ Clicking or popping of the jaw
□ Pain (joint, ear, side of face)
□ Difficulty chewing on either side of the mouth?
□ Headaches, neck aches, or shoulder aches?

Have you ever had:
□ Orthodontic treatment?
□ Periodontal Therapy?
□ A bite plate or mouth guard?
□ Oral Surgery?
□ Your teeth ground or bite adjusted?
□ A serious injury to the mouth or head? If so, describe:_____

AUTHORIZATION

I understand that the above information is necessary to provide me with dental care in a safe & efficient manner. I certify that the foregoing information is true and correct. Should further information be needed, you have my permission to contact the respective health care provider or agency, which may release such information to you. I will notify Moorestown Dental Professionals of any change in my health or medication at the next appointment time without fail. I understand that providing incorrect information may be dangerous to my health..

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____