Eric Josephson DMD

Patient Registration Form

Date of Appointment: ______________________

Patient Information

Patient's First Name		Middle Name		Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth (Age)		Social Security Number		
Patient's Address			City		State	Zip
Home Phone		Mobile Phone		Email Address		
Referred by						

Patient Employer/School Information

Employer/School	Occupation		Employer/School Phone	
Employer/School Address		City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Dental Insurance

Insurance Company		Plan		
Plan Number	Group Number	Insured's Employer/School		
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number	
Insured's Address		City	State	Zip
Insured's Social Security Number	Insured's Birthdate			

Secondary Dental Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient	
Address	City	State	Zip

______________________________ ______________________

Signature of Patient or Authorized Guardian Date

Eric Josephson DMD

Name ______ Gender ______ Age ______

Date of Appointment: ______

Reason for Visit

What brings you to the office today?

______

Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Hospitalizations & Surgeries

Reason	Date

Dental History

When was your last dental exam?

Date ______

When were your last dental x-rays taken?

Date ______

How often do you brush?

times/day ______

How often do you floss?

times/day ______

Do you grind your teeth?

☐ Yes ☐ No

Have you ever had orthodontic (braces) treatment?

☐ Yes ☐ No

Have you ever had periodontal (gum) treatments?

☐ Yes ☐ No

Do you have any of the following?

☐ Bad Breath ☐ Dry Mouth ☐ Partials
☐ Bleeding Gums ☐ Difficulty Chewing ☐ Sensitivity to Cold
☐ Blisters on Mouth ☐ Ear Pain ☐ Sensitivity to Heat
☐ Broken Fillings ☐ Jaw Pain ☐ Sensitivity to Sweets
☐ Clicking Jaw ☐ Loose Teeth ☐ Sensitivity to Pressure
☐ Dentures ☐ Mouth Pain ☐ Swollen Gums
☐ Difficulty Opening or Closing ☐ Mouth Sores

Past Medical History

Have you ever had any of the following?

☐ Alcoholism ☐ Bleeding Disorder ☐ Eating Disorder ☐ High Cholesterol ☐ Migraines ☐ Stomach Ulcer
☐ Allergies ☐ Blood Disease ☐ Epilepsy ☐ Joint Disorder ☐ Osteoporosis ☐ Substance Abuse
☐ Anemia ☐ Blood Transfusion ☐ Hay Fever ☐ Kidney Disorder ☐ Pacemaker ☐ Thyroid Disorder
☐ Anxiety Disorder ☐ Bowel Disorder ☐ Heart Disease ☐ Liver Disorder ☐ Rheumatic Fever ☐ Tuberculosis
☐ Arthritis ☐ Cancer ☐ Heart Problems ☐ Lung Disease ☐ Sinus Problems ☐ Venereal Disease
☐ Asthma ☐ Diabetes ☐ Hepatitis - A, B, or C ☐ Lupus ☐ Skin Disorder
☐ AIDS / HIV ☐ Depression ☐ High Blood Pressure ☐ Measles ☐ Stroke

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years ______ # packs/day ______

Do you smoke now?

☐ Yes ☐ No # packs/day ______

Do you use recreational drugs?

☐ Yes ☐ No types? ______ # times/week ______

How much alcohol do you drink per week?

drinks/week ______

How much caffeine do you drink per day?

drinks/day ______

Women Only

Are you pregnant?

☐ Yes ☐ No

Are you breastfeeding?

☐ Yes ☐ No

What is your method of birth control?

______