Dr. William Myers
2504 E. Center St.
Warsaw IN, 46580

PATIENT REGISTRATION

Patient's Name **Birth date** **Age** **Sex: M F**

Home Address | **City** | **State** | **Zip**

Home Phone # | ***YOUR E-mail address*** | **Your Soc Sec #**

Work Phone #

YOUR cell phone # | **YOUR Driver's License Number** **(is not necessary if you are paying at the time of service)**

Your Place of Employment: **Your Occupation**

Please Circle One: Single Married Separated Widow

If patient is minor we need:

Mother's Name & Birth date

Father's Name & Birth date

Person paying this bill:

Name of spouse (or parent if minor):

Spouse's (or parent's) employer **Spouse's Soc. Sec. #** **Work phone #**

EMERGENCY INFORMATION

Name, Address, & Telephone of
A relative not living with you:

Family Physician: Phone Number:

How did you hear about our office?

DENTAL INSURANCE INFORMATION (Primary Carrier)		**If you have a dual insurance coverage, complete this for the second coverage (this office bills primary ins only)**
Insured's name **DOB** **SS#**		Insured's name DOB SS#
Insured's employer		Insured's employer
Insurance Co		Insurance Co
Insurance Co Address		Insurance Co Address
Phone #		Phone #
Group # **Policy #**		Group # Local #

Patient Signature (or Parent of Child) **Date** **Dentist's Signature**

DENTAL HISTORY

Please check the following :	YES	NO
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL		
-Headaches, ear aches, neck aches or jaw joint pain	☐	☐
-Mouth ulcers or cold sores	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath	☐	☐
-Snoring	☐	☐
Do you have or have you had any of the following?	☐	☐
-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Gum treatments	☐	☐

	YES	NO
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco? How much? For how long?	☐	☐
If I could change my smile, I would:		
-Make my teeth whiter	☐	☐
-Make my teeth straighter	☐	☐
-Close spaces	☐	☐
-Replace metal fillings with tooth colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-Replace missing teeth	☐	☐
-Replace old crowns that don't match	☐	☐
-Have a smile makeover	☐	☐

Please share the following dates:

-Your last cleaning ___ / ___
-Your last oral cancer screening ___ / ___
-Your last complete X-Rays ___ / ___

Name of Previous Dentist _____
City _____ **State** _____
Phone Number _____

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?
_____

What is the most important thing to you about your future smile and dental health?
_____
_____

What is the most important thing to you about your dental visit today?
_____
_____

MEDICAL HISTORY

Y N	Y N	Y N	Y N
☐ ☐ Allergies (Seasonal)	☐ ☐ Excessive Bleeding	☐ ☐ Nervousness/Depression	☐ ☐ Ulcers
☐ ☐ Anemia	☐ ☐ Glaucoma	☐ ☐ Pacemaker	☐ ☐ OTHER (please list):
☐ ☐ Artificial Heart Valve	☐ ☐ Heart Conditions	☐ ☐ Phen Fen (1 month +)	_____
☐ ☐ Artificial Joints	☐ ☐ Heart Murmur	☐ ☐ Radiation (head/neck)	_____
☐ ☐ Asthma	☐ ☐ Hepatitis A	☐ ☐ Respiratory Problems	_____
☐ ☐ Blood Disease	☐ ☐ Hepatitis B	☐ ☐ Rheumatic Fever	_____
☐ ☐ Bruise Easily	☐ ☐ Hepatitis C	☐ ☐ Rheumatism	_____
☐ ☐ Cancer	☐ ☐ High Blood Pressure	☐ ☐ Scarlet Fever	_____
☐ ☐ Chemotherapy	☐ ☐ HIV/AIDS	☐ ☐ Seizures	**For WOMEN Only**
☐ ☐ Diabetes	☐ ☐ Jaundice	☐ ☐ Stomach Problems	❑ Birth Control Pills
☐ ☐ Dizziness/Fainting	☐ ☐ Kidney Disease	☐ ☐ Stroke	❑ Breast-feeding
☐ ☐ Drug Addiction	☐ ☐ Liver Disease	☐ ☐ Thyroid Disease	❑ Pregnant
☐ ☐ Emphysema	☐ ☐ Mitral Valve Prolapse	☐ ☐ Tuberculosis	1-3 mos,3-6 mos,6-9mos,

Do you have an allergy to any of the following?

☐ ☐ Aspirin ☐ ☐ Codeine
☐ ☐ Erythromycin ☐ ☐ Penicillin
☐ ☐ Latex ☐ ☐ Other:
☐ ☐ Local Anesthetic
☐ ☐ Nitrous Oxide

Are you under a physician's care? For what?
_____

What medications are you currently taking?
_____
_____
_____

Is there any other Medical or Dental Information **We Should Know About?**

Signature: _____