BRIDGEPORT
—FAMILY DENTAL—

PATIENT REGISTRATION

(Please fill out for your first visit.)

ID: _____ Chart ID: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Patient is ☐ Policy Holder ☐ Responsible Party ☐ Preferred Name:

Responsible Party (if someone other than patient):

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext.: _____ Cellular: _____

Birth Date: _____ Soc Sec.: _____ Drivers Lic.: _____

☐ Responsible Party is also Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State/Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext.: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic.: _____

E-mail: _____ ☐ I would like to receive correspondence via e-mail

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information:

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

BRIDGEPORT
—FAMILY DENTAL—

Patient Name:_____ Birth Date:_____

Although dental personnel primarily treat the area in and around your mouth. Your mouth is a part of your body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain:_____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain:_____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain:_____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain:_____
Do you take, or have you taken Phen-Fen or Redux?	Yes	No	_____
Are you on a special diet?	Yes	No	_____
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	

Women: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

Other If yes, please explain:_____

_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Breathing Problem	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No	Tonsilitis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	Heart Pace Maker	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No			

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain:_____

Comments:_____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE_____