# DeWitt Dental Associates Adult Patient Registration Form

We would like to welcome and thank you for joining out dental practice. We appreciate your confidence in us and we will do everything possible to provide you with the finest dental care.

**PATIENT INFORMATION** Date: _____

First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____ SSN# _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email: _____ Can we contact you through email or texting? ☐ Yes ☐ No

Occupation: _____ Employer: _____

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

**Emergency Contact:** Name: _____ Relation: _____ Phone # _____

Whom may we thank for referring you? _____

Hobbies/Interests: _____

**PRIMARY DENTAL INSURANCE:**

Insured's Name: _____ Relation: _____ Birth Date: _____

Insured's SS # _____ Insured's Employer: _____

Insurance Company Name: _____ Insurance Company Phone: _____

Insurance Policy # _____ Insurance Group Number: _____

**SECONDARY DENTAL INSURANCE**

Insured's Name: _____ Relation: _____ Birth Date: _____

Insured's SS # _____ Insured's Employer: _____

Insurance Company Name: _____ Insurance Company Phone: _____

Insurance Policy # _____ Insurance Group Number: _____

AUTHORIZATION AND RELEASE

I authorize the dentist and staff to perform any necessary services that I may need during diagnosis and treatment with my informed consent. I authorize the dentist and staff to release any information including diagnosis and records of any treatment or examination rendered to third party payer and/or health practitioners. I authorize and request my dental benefits company to pay directly to the dentist any insurance benefits otherwise payable to me, I understand my dental insurance provider may pay less than the actual bill for services. I agree to be responsible for payment of all service rendered for myself or my dependents. I Understand that payment is due at the time of service unless other arrangements have been made.

_____ _____

**Patient / Guardian Signature** **Date**

DO YOU REQUIRE ANTIBIOTIC PREMEDICATION FOR DENTAL PROCEDURES? ☐ Yes ☐ No

FEMALES: Are you Pregnant? ☐ Yes ☐ No Due Date: _____ Currently Breastfeeding? ☐ Yes ☐ No

**CARDIOLOGY**: Have you had or do you have?

_____ Heart Murmur
_____ Mitral Valve Prolapse
_____ Artificial heart valve/stents
_____ Congenital Heart Defects
_____ Bacterial Endocarditis
_____ Heart Pacemaker
_____ Heart Attack/Stroke
_____ High/Low Blood Pressure
_____ Rheumatic Fever
_____ Heart Surgery
Year _____

Name of Cardiologist: _____Phone:_____

Do you require medication for cardiac conditions? ☐ Yes ☐ No

Please list your current physician:_____ Phone:_____

**GENERAL MEDICAL INFORMATION: Have you had or do you currently have:**

____ Joint Replacement
____ Cancer/ Tumors/ Leukemia
Type: _____
____ Chemotherapy or Radiation
____ Cancer Medication Port
____ Blood Transfusions
____ Organ Transplants
____ Anemia
____ Sjogren's Syndrome
____ Vision Challenges/Contacts/Glasses
____ Hyperactive, ADD, ADHD
____ Other: _____
____ Sinus Problems
____ Emphysema
____ Thyroid Problems
____ Diabetes
____ Kidney Problems
____ Hepatitis A, B, C, D, E
____ Bleeding Disorders
____ Eating Disorders
____ Epilepsy, Seizures
____ Hearing Challenges
____ Asthma
____ Arthritis
____ HIV/AIDS
____ Drug or Alcohol Abuse
____ Tuberculosis or Positive TB Test
____ Osteoporosis, Osteopenia
____ STD's: Herpes, Syphilis…
____ Shingles
____ Alzheimer's, Memory Loss
____ Recent Surgeries, explain_____
_____

Previous Dentist: _____ Phone: _____ Last Visit: _____

Do you smoke or use chewing tobacco? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Do you have dental implants? ☐ Yes ☐ No

Year of placement _____

Do you use soda/sports drinks? ☐ Yes ☐ No

If yes, how many per week? _____

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you wear a bite splint? ☐ Yes ☐ No

Have you been, or are you currently under the care of a periodontist? ☐ Yes ☐ No

If yes, please provide name: _____ Phone: _____

Do you have dental concerns? ☐ Yes ☐ No If yes, please explain _____

ALLERGIES:

____ Penicillin products ____ Dental Anesthetics ____ Latex Products ____ Sulfa ____ Seasonal Allergies

____ Codeine ____ Aspirin ____ Bee Sting ____ Tetracycline

Please list any additional: _____

MEDICATIONS: Currently taking Pharmacy Used: _____

_____

_____

All information is accurate to the best of my knowledge:

Signature: _____ Date: _____

Dr. Signature: _____ Date: _____

Updates: (Please Date and Initial)

_____

_____

_____

_____