The DC Dentist
509 11TH ST SE.
Washington D.C 20003
(202) 544–3626/www.thedcdentist.com

Patient Registration Form

Patient Information **Date of Appointment:** _____

Patient First Name:	Middle Name:	Last Name:	
Gender:	Marital Status:	Date of Birth:	Social Security #
Patient's Address:	City:	State:	Zip Code:
Home Phone #	Mobile Phone #	E-mail address:	

How did you hear about us? _____

Emergency Contact Name:	Emergency Contact Phone:	Relationship to Patient:

Patient Employer / School Information

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

Billing and Insurance

Insurance Company/Plan:	Insurance Telephone Number:	
Plan Number:	Group Number:	Subscriber Employer / School
Subscriber Name (As it appears on insurance card or ID):		Relationship to patient:
Subscriber Address:	Subscriber date of birth:	
Secondary Insurance information Insurance Company:	Subscriber Employer / School	
Plan Number:	Date of Birth	
Subscriber Name	Relationship to patient:	

_____ _____

Signature of Patient or Authorized Guardian Date

Patient Name _____ **Date of Appointment** _____

Reason for today's visit

_____

_____

List of current medications:

_____

_____

Allergies:

_____

Are you allergic to any of the following?

☐ Local Anesthetics ☐ Penicillin ☐ Latex ☐ Sulfa
☐ Aspirin ☐ Iodine ☐ Codeine

Other: _____

Dental History:

Former Dentist: _____

When was your last dental exam? _____

When were your last dental x-rays taken? _____

How often do you brush? _____

How often do you floss? _____

Have you ever had a periodontal (gum) treatment? _____

Have you ever had orthodontic treatment? _____

Please check if any of the following conditions applies to the patient:

☐ Bad breath ☐ Dry Mouth ☐ Sensitivity to cold
☐Blisters on Mouth ☐ Ear Pain ☐ Sensitivity to Hot
☐ Broken Fillings ☐ Jaw Pain ☐ Sensitivity to Sweets
☐Difficulty Chewing ☐ Clicking Jaw ☐ Sensitivity when biting
☐ Loose Teeth ☐ Bleeding Gums
☐ Mouth Pain ☐ Swollen Gums

Medical History:

Physician's Name: _____ Date of Last Visit: _____

Have you had any serious illness or operations: ☐ Yes ☐ No If so, Please explain:

_____

Please indicate if any of the following medical conditions apply to your past or current medical history:

☐ Anemia	☐ Back Problems	☐ Diabetes	☐ Heart Problems	☐ Lupus
☐ Alcoholism	☐ Blood Disease	☐ Depression	☐ Epilepsy	☐ Hepatitis
☐ Arthritis, Rheumatism	☐ Cancer	☐ High Blood Pressure	☐ Migraines	☐ Skin Disorder
☐ Asthma	☐ Chemotherapy	☐ Glaucoma	☐ Kidney Disease	☐ Stroke
☐ Anxiety Disorder	☐ Chemical Dependency	☐ Headaches	☐ Liver Disease	☐ Venereal Disease
☐ HIV / AIDS	☐ Circulatory Problems	☐ Heart Murmur	☐ High Cholesterol	☐ Stomach Ulcer
☐ Fainting	☐ Tuberculosis			

Other (Please Specify):

Lifestyle Factors

Do you smoke? ☐ Yes ☐ No # of years # Packs/ day	**WOMEN ONLY** Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐No
Do you use recreational drugs? ☐ Yes ☐ No	
How much alcohol do you drink per week? # drinks per week	Are you taking birth control pills? ☐ Yes ☐ No
How much caffeine do you drink per day?	