CleanSmiles DENTISTRY

Patient Registration

Today's Date _____

Last Name _____ First Name _____MI _____ Date of Birth _____ Age ____
Sex **M** or **F** Soc. Sec. # _____ Please Circle: **Single Married Separated Widow**
Mailing Address _____ City _____ State ____ Zip Code _____
Email _____ Home Phone (___)_____ Cell Phone (___)_____
Driver's License # _____ Employer _____
Occupation _____ Occupation _____
Are you a full time student? **Yes** or **No** If patient is a minor: Mother's DOB _____ Father's DOB _____

Name of Parent _____ Parent Soc. Sec. # _____
Parent Employer _____ Parent Phone (_____)_____
Person Responsible for Account _____ Relationship _____
Emergency Contact _____ Relationship _____ Phone # (_____)_____

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name _____ Relationship _____
Reason for today's visit? _____
How did you hear about us?
___In-home Mailer ___Social Media ___Insurance ___Practice Website ___Internet ___Family/Friend/Coworker
Other_____ Who can we thank for your visit? _____

Dental Insurance Information (Primary Carrier)
Insured's Name _____
Insured's Employer _____
Insured's DOB _____
Insurance Co _____
Insurance Co Address _____
Insurance Phone # _____
Group # _____ Local # _____

Dental Insurance Information Secondary Coverage
Insured's Name _____
Insured's Employer _____
Insured's DOB _____
Insurance Co _____
Insurance Co Address _____
Insurance Phone #_____
Group # _____ Local # _____

Dental History

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
Where do you want your dental health to be?	1	2	3	4	5	6	7	8	9	10
What would you like to change about your smile?	1	2	3	4	5	6	7	8	9	10

__ Color __ Bite __ Chipped Teeth __ Spaces __ Crowding __ Smile Makeover __ Missing Teeth __ Whiter Teeth

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Clermont, FL 34711

407.602.7440
www.cleansmilesdentistry.com

Patient Registration - *continued* - Patient Name (print) _____

Please share the following dates:

Your last cleaning _____/_____ Your last oral cancer screening _____/_____ Your last complete X-rays _____/_____
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? _____
_____
Why did you leave your previous dentist?_____
_____
Name of your previous dentist
_____

Please mark (x) any of the following conditions that apply to you:

Appearance
__Discolored teeth
__Worn teeth
__Misshaped teeth
__Crooked teeth
__Spaces
__Overbite
__Flat teeth

Pain/Discomfort
__Sensitivity (hot, cold, sweet)
__Pressure
__Broken teeth/fillings
__Worn teeth
__Dry Mouth

Function
__Grinding/Clenching
__Headaches
__Jaw Joint (TMJ) pain
__Jaw Joint (TMJ) clicking/popping
__Bad Bite
__Speech Impediment
__Mouth Breathing
__Sore Muscles (neck, shoulders)
__Difficulty Opening or Closing
__Difficulty Chewing on either side

Periodontal (Gum) Health
__Bleeding, Swollen, Irritated gums
__Bad breath
__Loose tipped, shifting teeth
__Previous perio/gum disease

Habits
__Thumb sucking
__Nail-biting
__Cheek/Lip biting
__Chewing on ice/ foreign objects

Sleep Patterns/ Conditions
__Sleep Apnea
__Snoring
__Daytime Drowsiness
__Bed wetting (children)

Previous Comfort Options
__Nitrous Oxide
__Oral Sedation (Pill)
__IV Sedation

Social
Tobacco
How much ____
How long ____
Alcohol Frequency
_____
Drugs Frequency
_____

Please list family history conditions marked:
_____
_____
_____
_____
_____
_____

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Patient Registration - *continued* - Patient Name (print) _____

Medical History - Please mark (x) to your response to indicate if you have or have had any of the following:

Cardiovascular
__Angina (chest pain)
__Artificial Heart Valve
__Heart Attack
__Heart Conditions
__Heart Surgery
__High/Low Blood Pressure
__Mitral Valve Prolapse
__Pacemaker
__Rheumatic Fever
__Scarlet Fever
__Stroke

Endocrinology
__Diabetes
__Hepatitis A/B/C
__Jaundice
__Kidney Disease
__Liver Disease
__Thyroid Disease

Gastrointestinal
__Ulcers (Stomach)
__Gastrointestinal Disease

Musculoskeletal
__Arthritis
__Artificial Joints
__Jaw Joint Pain
__Rheumatoid Arthritis

Neurological
__Anxiety
__Depression
__Dizziness
__Drug/Alcohol Addiction
__Fainting
__Seizures

Respiratory
__Asthma
__Emphysema
__Respiratory Problems
__Sinus Problems
__Sleep Apnea
__Tuberculosis

Viral Infections
__AIDS
__HIV Positive
__HPV
__Herpes
__Hepatitis A/B/C
__Psychiatric Illness

Cancer
Type_____
__Chemotherapy
__Radiation Therapy

Hematologic/ Lymphatic
__Anemia
__Blood Disorders
__Bruise Easily
__Excessive Bleeding

Women
__ Pregnant
__Nursing

Medical Allergies
__Antibiotics (penicillin/amoxicillin /clindamycin)
__Opioids (hydrocodone, oxycodone, codeine)
__Latex
__Local Anesthetics
__NSAIDs
__Other Allergies _____ Additional Comments: _____

Are you under the care of a physician? **Y** or **N** If yes, please explain _____
_____
Physician Name_____ Address:_____ Phone(___)_____
Have you had a serious illness, operation, or hospitalization in the past 5 years? **Y** or **N**, If yes please explain
_____
_____
Are you taking or have you recently taken any prescription or over the counter medicine(s)? **Y** or **N** If yes, please list all and why, including vitamins, natural or herbal supplements and/or dietary supplements _____
_____
_____
_____

Have you ever in the past, or are you now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease? If so, please list medications:_____
Have you ever had surgery? If so, what type:_____

Patient Registration - *continued* - Patient Name (print) _____

Consent:
The undersigned hereby authorizes Dr. Raymund Kwong DMD to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Kwong to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Kwong to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____
Patient Name (Printed) Signature Date (m/d/y)

_____
Dentist Signature

****

For Office Use Only
For completion by dentist only | Additional Comments:

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