


  
**REGISTRATION FORM**
  
 (Please Print)

**All About Smiles Family Dentistry**  
 13 St. Johns Medical Park Drive  
 Saint Augustine, Florida 32086  
 (904) 797-4064  
 YourSmileTeam@AllAboutSmilesDMD.Com

Today's Date:				SS/HIC/Patient ID #:			
PATIENT INFORMATION							
Patient's Last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/>	
Home Phone: ( ) ( )	Cell Phone: ( ) ( )		Email:		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Best Way To Reach You: Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Postal Mail <input type="checkbox"/>		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:				Employer phone no.: ( ) ( )	
Chose clinic because/referred to clinic by (Please check one box):			<input type="checkbox"/> Dr.'s Office:		<input type="checkbox"/> Friend/Family :		
<input type="checkbox"/> Our Website	<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Google	<input type="checkbox"/> Bing	<input type="checkbox"/> Yahoo	<input type="checkbox"/> Phonebook:		
Other family members seen here:							

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ( ) ( )	Work phone no.: ( ) ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	

DENTAL HISTORY			
Reason for today's Visit:	Former Dentist: City/State:	Date of Last Dental Visit:	Date of Last Dental X-Rays:
Please place a mark on "yes" or "no" to indicate if you have had any of the following			
Bad Breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bleeding Gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No	
Blistering on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding Teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No	
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cigarette/pipe/cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip and cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	
Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to: <input type="checkbox"/> Sweets <input type="checkbox"/> Biting	
Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to: <input type="checkbox"/> Cold <input type="checkbox"/> Heat	
Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip and cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	
		How often do you floss? _____	
		How often do you brush? _____	

## HEALTH HISTORY

Physician's Name:	Date of last visit:	Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" <small>These include combinations of Ionimin, Adipex, Fastin (brand name of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).</small> <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Abnormally w/ extractions or surgery . <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head/neck <input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody <input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, Unexplained <input type="checkbox"/> Yes <input type="checkbox"/> No

<p><b><u>Women:</u></b></p> <p>Are you Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Taking Birth Control? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Due Date: _____</p> <p>Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b><u>Medications</u></b></p> <p>List any medications you are currently taking and the correlating diagnosis:</p>  <p>Pharmacy Name: _____</p> <p>Phone Number: _____</p>	<p><b>Allergies</b></p> <p><input type="checkbox"/> Aspirin</p> <p><input type="checkbox"/> Barbiturates (Sleeping Pills)</p> <p><input type="checkbox"/> Codeine</p> <p><input type="checkbox"/> Iodine</p> <p><input type="checkbox"/> Latex</p> <p><input type="checkbox"/> Local Anesthetic</p> <p><input type="checkbox"/> Penicillin</p> <p><input type="checkbox"/> Sulfa</p> <p><input type="checkbox"/> Other</p>
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