ANDREW WHEATLEY, DDS
AT TECUMSEH RIDGE DENTAL

Dental Registration and Patient History

Thank you for choosing our office to assist you with your dental needs.
Please fill out the information below and don't forget to provide your signature at the end.

Patient's name _____ Date of Birth _____ Gender:_____

If minor, name of legal guardian_____

Mailing address _____ City _____State _____ Zip _____

Home phone _____ Mobile phone _____ Work phone _____

Email address:_____

Employer: _____

Emergency Contact:_____ Relationship:_____ Phone _____

Primary physician: _____ Date of last visit: _____

Previous dentist: _____ Date of last visit: _____ Date of last X-Ray _____

Reason for today's visit: _____

What is your preferred pharmacy: _____

How did you hear about us? (Circle all applicable)
Referral from friends or Family, Internet search, Social Media, Mailer, Directory, Signs or Billboards

How may we contact you?(Circle all applicable)
Phone, Text, Email

INSURANCE INFORMATION:

Covered / not covered by dental insurance (circle one)

Your SS# : _____ or Member ID#_____
Dental Insurance Co._____ Group number_____ Claims Address_____

Covered by spouse's insurance? Yes No Spouse's Name _____
Spouse's dental insurance company _____ Group number _____
Spouse's birthday _____ SS# or Member ID# _____

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Dental History

Do your gums bleed while brushing or flossing?	Y	N	Do you bite your lips or cheeks frequently?	Y	N
Are your teeth sensitive to hot or cold liquids/foods?	Y	N	Have you noticed any loosening of your teeth?	Y	N
Are your teeth sensitive to sweet or sour liquids/foods?	Y	N	Does food tend to become caught between your teeth?	Y	N
Do you experience any tooth pain?	Y	N	Have you ever had periodontal treatment (gums)?	Y	N
Do you have any sores or lumps in or near your mouth?	Y	N	Have you ever worn a bite plate or other appliance?	Y	N
Have you had any head, neck, or jaw injuries?	Y	N	Have you had any difficult extractions in the past?	Y	N
Have you experienced any of the following problems:			Have you ever had any prolonged bleeding following extractions?	Y	N
Clicking in your jaw	Y	N	Do you wear dentures or partials?	Y	N
Pain (joint, ear, side of face)	Y	N	If yes, give the date they were placed _____		
Difficulty in opening or closing your jaw	Y	N	Have you ever received oral hygiene instructions for the care of your teeth and gums?	Y	N
Difficulty in chewing	Y	N	Have you had your wisdom teeth removed?	Y	N
Do you have frequent headaches?	Y	N	Are you concerned about bad breath?	Y	N
Do you clench or grind your teeth?	Y	N			
Would you like whiter teeth?	Y	N			

Health History

Do you have, or have you had any of the following? (Please check any that apply)

Are you required to pre-medicate with antibiotics before any dental treatment?	Y	N
Blood Problems (e.g. anemia)	Y	N
Blood transfusion	Y	N
Heart problems	Y	N
Heart murmur, mitral valve prolapse, congenital heart defect,	Y	N
Heart Pacemaker	Y	N
Stroke	Y	N
Bone or joint problems	Y	N
Artificial joint or valves	Y	N
High or low blood pressure (circle one)	Y	N
Tuberculosis or other lung problems	Y	N
Kidney disease	Y	N
Hepatitis, jaundice or other liver disease	Y	N
Diabetes TYPE 1 or TYPE 2	Y	N
Epilepsy or Neurological disorders	Y	N
Thyroid problems	Y	N
Arthritis	Y	N
Herpes or cold sores	Y	N
AIDS or HIV positive	Y	N
Cancer/Tumor	Y	N
Abnormal bleeding after any surgery	Y	N
Hay Fever or sinus trouble	Y	N
Anxiety disorder	Y	N
Asthma	Y	N
Bleeding Disorders	Y	N

Are you allergic to, or have you reacted adversely to any of the following?

Latex	Y	N
Penicillin or other antibiotics	Y	N
Local anesthetics	Y	N
Codeine or other narcotics	Y	N
Sulfa drugs	Y	N
Barbiturates, sedatives or sleeping pills	Y	N
Aspirin	Y	N
Other:_____		

Are you taking any of the following?

Aspirin	Y	N
Anticoagulants (blood thinners e.g. Coumadin)	Y	N
Antibiotics or sulfa drugs	Y	N
High blood pressure medicine	Y	N
Antidepressants or tranquilizers	Y	N
Insulin other diabetes drugs	Y	N
Nitroglycerin	Y	N
Cortisone or other steroids	Y	N
Osteoporosis medicine (Bisphosphonates e.g. Fosamax, Zometa, Actonel)	Y	N
Natural supplements	Y	N

List all other medication:

_____

_____

_____

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Eating Disorders	Y N	_____
Rheumatic Fever	Y N	_____
Psychiatric Care	Y N	**Do you smoke, vape or use tobacco?** Y N

Women only:

Are you currently pregnant or plan to become pregnant?	Y N
Are you nursing?	Y N
Taking hormones or contraceptives?	Y N

Have there been any significant updates since your last visit?

Dental: _____
Health: _____
Allergies: _____
Medication: _____
New/different insurance: _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

_____ _____

Signature of patient or guardian of minor Date

_____ _____

Signature of Doctor Date