MILPITAS DENTAL CENTER
FAMILY DENTISTRY

Adult Registration Form

1101 South Park Victoria Dr, Milpitas, CA 95035 · (408) 263-9343

The benefits of a happy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's date | E-mail address

Last name | First | MI | ☐ Mr ☐ Mrs ☐ Ms ☐ Dr

I prefer to be called | ☐ Male ☐ Female

Birthday | Age | Social Security #

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home address: Street | City | State | Zip

Home phone | Cell | Work phone | Ext.

Where & when are the best times to reach you?

Whom may we thank for referring you?

Other family members seen by us

Employer | How long there? | Occupation

Employer's address: Street / PO Box | City | Zip

Neighbor or relative not living with you

Name | Relation | Work phone | Home phone

Address: Street | City | State | Zip

Insurance Information

Primary insurance

Insurance company | Phone | Group # (plan, local or policy #)

Ins. Co. address: Street / PO Box | City | State | Zip

Insured's name | Insured's Social Security # | Insured's birthday | Relation

Insured's employer

Spouse information

Name | Birthday | Social Security #

Employer | Work phone | Ext.

Insurance company | Phone | Group # (plan, local or policy #)

Ins. Co. address: Street / PO Box | City | State | Zip

Person responsible for account

Dental History

Why have you come to the dentist today?

Previous / present dentist | Last visit date

Why did you leave your last dentist?

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you floss daily? ☐ Yes ☐ No

Do you brush daily? ☐ Yes ☐ No

Toothbrush bristles ☐ Hard ☐ Medium ☐ Soft

Do your gums ever bleed? ☐ Yes ☐ No

Do your gums ever itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you have mobility in your teeth? ☐ Yes ☐ No

Do you have or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

Do you want to learn more about whitening? ☐ Yes ☐ No

Have you ever had any serious complications with prior dental treatment? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold or anything else?

If you would change your smile, what would you change?

If you had complications with prior treatment, what were they?

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Are you currently under the care of a physician? ☐ Yes ☐ No

Physician's name | Phone | Date of last visit

If under a physician's care, please explain

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Phen-Fen, Redux or Pondimin? ☐ Yes ☐ No

For women: are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No ☐ Unsure

Are you nursing? ☐ Yes ☐ No

If pregnant, week #

Do you have or have you experienced the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Difficulty Breathing	☐	☐	Hepatitis	☐	☐	Scarlet Fever
☐	☐	Alcohol Abuse	☐	☐	Drug Abuse	☐	☐	Herpes	☐	☐	Seizures
☐	☐	Anemia	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Shingles
☐	☐	Arthritis	☐	☐	Epilepsy	☐	☐	HIV+ / AIDS	☐	☐	Sickle Cell Disease
☐	☐	Artificial Bones/Joints	☐	☐	Ever Hospitalized	☐	☐	Kidney Problems	☐	☐	Sinus Problems
☐	☐	Artificial Valves	☐	☐	Fainting Spells	☐	☐	Liver Disease	☐	☐	Steroid Therapy
☐	☐	Asthma	☐	☐	Fever Blisters	☐	☐	Low Blood Pressure	☐	☐	Stroke
☐	☐	Blood Transfusion	☐	☐	Glaucoma	☐	☐	Lupus	☐	☐	Thyroid Problems
☐	☐	Cancer	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis
☐	☐	Chemotherapy	☐	☐	Headaches	☐	☐	Pacemaker	☐	☐	Tuberculosis (TB)
☐	☐	Chicken Pox	☐	☐	Heart Attack	☐	☐	Persistent Cough	☐	☐	Ulcers
☐	☐	Colitis	☐	☐	Heart Murmur	☐	☐	Psychiatric Problems	☐	☐	Venereal Disease
☐	☐	Congenital Heart Defect	☐	☐	Heart Surgery	☐	☐	Radiation Treatment			
☐	☐	Diabetes	☐	☐	Hemophilia	☐	☐	Rheumatic Fever			

Please list any serious medical conditions that you have experienced:

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

If yes, please list each one:

Are you allergic to any of the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Dental Anesthetics	☐	☐	Latex	☐	☐	Sulfa Drugs
☐	☐	Barbiturates	☐	☐	Erythromycin	☐	☐	Penicillin	☐	☐	Tetracycline
☐	☐	Codeine	☐	☐	Jewelry / Metals	☐	☐	Sedatives	☐	☐	Other

If other allergies, please list

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature Date

Type your full name, or sign by hand after printing.

I understand photos taken of my teeth, smile, or portrait may be displayed for patient educational purposes.

Signature Date

Type your full name, or sign by hand after printing.