Michael S. Reilly, DDS
Family Dentistry

Patient Registration Form

Today's Date:

Our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name (Last, First, Middle):

Date of Birth (month, day, year):

Sex (male, female):

Address (mailing address):

Home Phone:

Cell Phone:

Email:

Occupation:

SS#:

If you are completing this form for another person, what is your relationship to that person? (name, relationship):

Do you have any of the following diseases or problems:

Active Tuberculosis …… YES/ NO
Persistent cough greater than a 3 week duration …… YES/ NO
Cough that produces blood …… YES/ NO
Been exposed to anyone with tuberculosis …… YES/ NO
(If you answer yes to any of the 4 items above, please stop and return this form to the receptionist)
Orthopedic total joint (hip, knee, elbow, finger) **replacement**? …… YES/ NO
Date: _____
(If you answered yes to the question above, please contact your physician in regards with taking antibiotic premedication before your dental visits)
Prosthetic cardiac valve …… YES/ NO
Previous endocarditis …… YES/ NO
Congenital heart disease …… YES/ NO
Cardiac transplantation recipients with cardiac valvular disease …..… YES/ NO
(AHA recommends that patients premedicate before dental treatments, if they have any of the 4 conditions listed above)

Insurance Information

Name of insurance policy:

Subscriber's name:

Subscriber's date of birth:

Subscriber's insurance number:

Subscriber's Group Number:

Dental information

Do your gums bleed when you brush or floss? .....

Are your teeth sensitive to cold, hot, sweet or pressure? .....

Does food or floss catch between your teeth? .....

Is your mouth dry? .....

Have you had any periodontal (gum) treatments? .....

Have you ever had orthodontic (braces) treatment? .....

Have you had any problems associated with previous dental treatment? .....

Is your home water supply fluoridated? .....

Do you drink bottled or filtered water? .....

Are you currently experiencing dental pain or discomfort? .....

Do you have earaches or neck pains? .....

Do you have any clicking, popping or discomfort in the jaw? .....

Do you grind your teeth? .....

Do you have sores or ulcers in your mouth? .....

Do you wear dentures or partials? .....

Do you participate in active recreational activities and sports? .....

Have you ever had a serious injury to your head or mouth? .....

What is the reason for your dental visit today? .....

How do you feel about your smile? .....

……..

Note: Patients are encouraged to discuss any relevant health issues prior to treatment.
I certify that I have read and understand the above that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omission that I may have made in the completion of this form.
I understand that I will be responsible for any payments on my account. Payments are due on the day of the visit, unless you have made special arrangements with our office. I also understand that if I am unable to make my appointment, I will be responsible for providing the office with a 24-hour notice and any fees that may apply.

Signature of Patient/ Legal Guardian: Date: