W. Huntington Dr. Ste. 3
ARCADIA, CA 91007
tele: 626.577.8880
fax: 626.577.8811

Patient Registration

• required

Personal Information

• First Name: ______________________
• Address: ______________________
• State/Zip: ______________________
• Home Phone: ______________________
• Email: ______________________

• Last Name: ______________________
• City: ______________________
• Work Phone: ______________________
• Other: ______________________
• Date of Birth: ______________________

Spouse/Partner: ______________________
Insured's Name: ______________________
Insurance Name: ______________________

2nd Insurance: ______________________

Emergency Contact: ______________________
Dentist Name: ______________________

Employer: ______________________
Relationship: ______________________
Plan Name: ______________________
Group#: ______________________
Plan Name: ______________________
Group #: ______________________
Phone Number: ______________________
Referral Source:______________________

Dental History

What is the reason for your visit?
(Provide as much information as possible, use back if nec.)

When was your last full mouth mouth x-rays series taken?

When was your last cleaning?

Please check all that apply:

- [ ] I do not brush regularly
- [ ] I do not floss regularly
- [ ] My gums bleed
- [ ] My teeth are sensitive to hot/cold
- [ ] I have discomfort or clicking in my jaw joint
- [ ] I do not use powered toothbrush (Sonicare)
- [ ] When I eat, food catches between my teeth
- [ ] I do not like my smile

Medical History

Please check all that apply:

- [ ] I am currently under physician's care
- [ ] I have been hospitalized or had a major operation
- [ ] I am not in good health
- [ ] I bruise easily
- [ ] I smoke
- [ ] I take medications
- [ ] I am allergic to Latex
- [ ] I am pregnant or nursing
- [ ] I am trying to get pregnant

Physician Name: ________________ Phone Number: ________________

Hospitalization Details:
(Provide as much information as possible, use back if nec.)

I am Allergic to the following medications:

- [ ] Heart Disease
- [ ] Diabetes
- [ ] Stroke
- [ ] Heart Murmur
- [ ] Epilepsy
- [ ] Kidney Disease
- [ ] Rheumatic Fever
- [ ] Liver Disease
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Blood Disease
- [ ] Recent Blood Transfusion
- [ ] Cortisone Medicine
- [ ] Tuberculosis
- [ ] Ulcer
- [ ] AIDS/HIV +
- [ ] Radiation Treatment
- [ ] Tumor History
- [ ] Chemotherapy
- [ ] Pace Maker
- [ ] Drug/Alcohol Addiction
- [ ] Venereal Disease
- [ ] Psychiatric Care
- [ ] Thyroid Disease

Other Comments & Questions:

•I would Like to Schedule a:

- [ ] 30 Minute Consultation (Please bring along your x-rays, if available)
- [ ] Comprehensive 1 Hour Dental Implant Examination