Welcome! The benefits of a healthy smile a immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out t forms completely. The better we communicate, th better we care for you!

wright smiles

gregory wright, dds | paola arcila, dds | victoria heron, dds

PATIENT REGISTRATION

Name ______________________ I Like To Be Called ______________________

Spouse/Parent's Name If Child ______________________ Date ______________________

Address ______________________

City ______________ State ______________ Zip ______________ Email ______________________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Birthdate ______________ Age ______________ Gender M or F Martial Status ______________

Social Security Number ______________ Who May We Thank For Referring You? ______________

Emergency Contact ______________ Contact Phone ______________ Relationship to Patient ______________

Is Another Member of your Family a Patient at our Office? Y or N Names: ______________ Relationship to Patient ______________

____

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name ______________ DOB ______________

Relationship To Patient ______________ SSN# ______________

Address ______________________

City ______________ State ______________ Zip ______________

Home Phone ______________ Cell ______________

Email ______________________

DENTAL INSURANCE

Insurance Company ______________________

Insurance Company Phone ______________________

Group No. ______________________

Employee ______________________

Date of Birth ______________________

Employee SS# ______________________

Subscriber ID# ______________________

ABOUT YOU

Employer ______________ Yrs Employed ______________

Occupation ______________________

Business Address ______________________

City ______________ State ______________ Zip ______________

Business Phone ______________________

Other ______________________

ABOUT YOUR SPOUSE

Employer ______________ Yrs Employed ______________

Occupation ______________________

Business Address ______________________

City ______________ State ______________ Zip ______________

Business Phone ______________________

Other ______________________

CONSENT

CONSENT FOR TREATMENT FOR ____

PLEASE PRINT PATIENT'S NAME

I attest that to the best of my knowledge the information provided is accurate and complete. Any changes in health status or medications will be reported to the Doctor at the next visit following the change. In addition I authorize the Doctor or his representative to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis and to develop proper treatment recommendations. I also authorize the Doctor to perform all forms of treatment, medication, and therapy that may be indicated, and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made in advance.

SIGNATURE ______________________________ DATE ______________

☐ PATIENT ☐ PARENT ☐ GUARDIAN

(TURN OVER TO COMPLETE)

MEDICAL HISTORY

General Health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of Physician Phone No.

Have you been under medical care in the last 2 years? ☐ Yes ☐ No If Yes, Explain

Last complete physical Last blood pressure check Blood pressure

List all medications you take

Have you been treated for:

Condition		
Acquired Immune Deficiency Syndrome (Aids/Hiv)	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
What Type ______		
Radiation Treatment	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Dry Mouth (Xerostomia)	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Hepatitis or Jaundice	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Abnormal Blood Pressure	☐ Yes	☐ No
Congenital Heart Defects	☐ Yes	☐ No
Murmur	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Joint Replacement	☐ Yes	☐ No
If Yes, Premed? ______	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Osteoporosis Drugs	☐ Yes	☐ No
Sinus Troubles/Allergies	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
VD (syphilis, gonorrhea, hpv)	☐ Yes	☐ No

Are You Allergic To: ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Latex ☐ Other Medicines: List Others:

Antibiotic premedication needed prior to dental appointment? ☐ YES ☐ NO

Are You Subject to Prolonged Bleeding ☐ Yes ☐ No

Fainting Spells or Dizzy Spells ☐ Yes ☐ No

Do You Have Any Condition Not Listed ☐ Yes ☐ No If Yes, Explain ______

(Women) Are You Pregnant ☐ Yes ☐ No Due Date?

Taking Birth Control ☐ Yes ☐ No Nursing ☐ Yes ☐ No

DENTAL HISTORY

Date of last dental visit Dentist's Name Phone No.

Did you have X-Rays taken ☐ Yes ☐ No Date of last dental cleaning

Do you wear full or partial dentures ☐ Yes ☐ No If Yes, how old are they

Question		
Have you had all of your teeth x-rayed in the past 3 years	☐ Yes	☐ No
Are you dissatisfied with the appearance of your teeth or smile	☐ Yes	☐ No
Would you change your smile if your could	☐ Yes	☐ No
Do you snore or have sleep apnea	☐ Yes	☐ No
Have you had orthodontic treatment	☐ Yes	☐ No
Do you clench or grind your teeth during the day or night	☐ Yes	☐ No
Have you ever had a pain in your jaw joint or your face or around your ear	☐ Yes	☐ No
Does your jaw joint click or pop	☐ Yes	☐ No
Do you have difficulty opening your mouth widely	☐ Yes	☐ No
Do you have an unpleasant odor, or taste in your mouth	☐ Yes	☐ No
Do your gums bleed when brushing	☐ Yes	☐ No
Have you ever been diagnosed with gum disease	☐ Yes	☐ No
Is your mouth or teeth sensitive to: Pressure ☐ Yes ☐ No … Cold ☐ Yes ☐ No … Hot	☐ Yes	☐ No
Does food catch between your teeth	☐ Yes	☐ No
Do you have difficulty getting numb for dental treatment	☐ Yes	☐ No
Do you currently or in the past; smoke use smokeless tobacco or vape?	☐ Yes	☐ No

Please add anything you feel is important for the Doctor to know (Any special concerns)