



REGISTRATION FORM

Welcome to our office! Dr. Ruhl and his staff wish to extend their greetings to you and thank you for trusting us to provide you with gentle, competent care. So that we may get to know you better, please take a moment to fill out this form as completely as you can.

Today's Date: _____ Name: _____

You prefer to be called: _____

Home Phone:(_____) _____ Work :(_____) _____ Cell:(_____) _____

Email address: _____

Birth Date: ____/____/____ Age: _____ Social Security #: _____

Mailing Address: _____

Physical Address: _____

City, State & Zip: _____

Where are you employed? _____ Other family members seen by us: _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician: _____ Are you currently under the care of a physician? _____

Please explain: _____

In the event of an emergency whom should we notify _____ Phone _____

Are you taking any prescription and/or over the counter drugs? ___ Yes ___ No

If yes, please list _____

Please list any serious medical conditions you may have had: _____

Are you allergic to any of the following:

___ Aspirin ___ Codeine ___ Dental Anesthetics ___ Erythromycin ___ Latex ___ Penicillin ___ Tetracycline
___ Jewelry ___ Metals ___ Seaweed ___ Sulfa

Please list any other drugs that you are allergic to: _____

Do you use tobacco? ___ Yes ___ No

For Women: Are you taking Birth Control Pills? ___ Yes ___ No

Are you pregnant? ___ Yes ___ No Week #: _____ Are you Nursing? ___ Yes ___ No

Have you ever had any of the following diseases, medical problems and/or treatments?

___ Anemia ___ Artificial Joints ___ Artificial Valves ___ Asthma ___ Arthritis ___ Back Problems ___ Cancer ___ Chemotherapy
___ Congenital Heart Defect ___ Diabetes ___ Difficulty Breathing ___ Drug Abuse ___ Alcohol Abuse ___ Emphysema
___ Epilepsy/Convulsions ___ Fever Blisters/Herpes ___ Glaucoma ___ Heart Attack ___ Heart Murmur
___ Heart Surgery/Pacemaker ___ Hemophilia/Abnormal Bleeding ___ Hepatitis ___ High / Low Blood Pressure ___ HIV+ / AIDS
___ TMJ ___ Kidney Problems ___ Liver Problems ___ Leukemia ___ Mitral Valve Prolapse ___ Ophthalmic Eye Surgery
___ Psychiatric Problems ___ Rheumatic Fever ___ Severe/Frequent Headaches ___ Shingles ___ Sinus Problems ___ Ulcers
___ Thyroid Problems ___ Tuberculosis ___ Venereal Disease ___ X-ray or Cobalt Treatment

Do you require antibiotic Pre-Medication? ___ Yes ___ No

SEE REVERSE SIDE

DENTAL INSURANCE

Primary Dental Insurance Carrier: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (_____) _____

Group # (Plan or Local #): _____ Insured's Employer: _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: ____/____/____ Insured's Social Security #: _____

AUTHORIZATION FOR TREATMENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any change in my medical status. *I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.*

Signature _____ Date _____

DENTAL HISTORY

Date of Last Dental Visit: _____ Name of Previous Dentist: _____

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Have you had any serious problems with any previous dental work? Yes No

If Yes, Explain _____

Your current dental health is: Good Fair Poor

Do you like your smile? _____ Do your gums bleed? _____

How many times a week do you floss? _____ Have you had dental care instructions? _____

How many times a day do you brush? _____ Do you use a Hard Medium Soft brush

Have you been treated for periodontal disease? _____