Wilmington
Dental Studio
Dr. Abrahamian & Dr. Orchanian

Patient Registration Form

PATIENT INFORMATION

First Name		Middle Initial		Last Name	
Nickname		Gender	❑ Male ❑ Female	Birth Date	
Social Security #		Driver's License #		E-mail	
Address		City		State		ZIP Code	
Home Phone		Cell Phone		Work Phone	
Marital Status	❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single				
Employer		Business Telephone			

WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE?

❑ Current Patient ❑ Referring Doctor ❑ Internet ❑ Insurance ❑ Other: ____________________

Referral Name	

EMERGENCY CONTACT

First Name		Last Name	
Relationship to Patient		Telephone	

INSURANCE INFORMATION

Do you have dental insurance?	❑ Yes ❑ No

We submit to your insurance as a courtesy to you. In the event your insurance pays less than the estimated amount, you are responsible for the unpaid balance. All balances over 90 days will be subject to 1.5% (18%) monthly finance charge.

PRIMARY DENTAL INSURANCE COMPANY

Primary Policy Holder	First	Last			
Relation		Gender	❑ Male ❑ Female	Birth Date		S.S. #	
Insurance Co. Name		Telephone			
Address		City		State		ZIP Code	
Group #		Member ID#			

Do you have secondary dental insurance?	❑ Yes ❑ No

SECONDARY DENTAL INSURANCE COMPANY

Primary Policy Holder	First	Last			
Relation		Gender	❑ Male ❑ Female	Birth Date		S.S. #	
Insurance Co. Name		Telephone			
Address		City		State		ZIP Code	
Group #		Member ID#			

HEALTH HISTORY

Are you under the care of a physician? If yes, please complete the line below.					❑ Yes ❑ No
Date of Last Visit		Physician Name		Physician Phone	
Any hospitalization, surgeries or serious illnesses in the past?					❑ Yes ❑ No
Please explain					
Any history of head & neck radiation?					❑ Yes ❑ No
Do you smoke, vape or use any form of tobacco?					❑ Yes ❑ No
Are you required to "pre-medicate" before any dental treatment?					❑ Yes ❑ No

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Do you have, or have had, any of the following?

	Yes	No		Yes	No
Heart problems			Hepatitis or jaundice or other liver disease		
Heart pacemaker			Diabetes Type 1		
Stroke			Diabetes Type 2		
Bone or joint problems			Epilepsy		
Artificial joint or valves			Neurological disorders		
High blood pressure			Cancer or tumor		
Low blood pressure			Abnormal bleeding		
Tuberculosis or other lung problems			Allergies		
Kidney disease			Asthma		

Is there any disease, condition, or problem that you think our office should know about that is not listed above? If yes, please list below. ❑ Yes ❑ No

FOR WOMEN ONLY

Are you pregnant?	❑ Yes ❑ No	If yes, number of weeks	

MEDICATIONS

Are you taking any of the following?

	Yes	No		Yes	No
Antibiotics or sulfa drugs			High blood pressure medicine		
Antidepressants or tranquilizers			Insulin or other diabetes drugs		
Anticoagulants *(blood thinners e.g. Coumadin)*			Natural supplements		
Aspirin			Nitroglycerin		
Cortisone or other steroids			Osteoporosis medicine *(bone density)*		

ALLERGIES/REACTIONS

Are you allergic to, or had a reaction to any of the following?

	Yes	No		Yes	No
Aspirin			Local anesthetics		
Metal			Penicillin or other antibiotics		
Latex			Sulfa drugs		
Other					

Please list any allergy/reaction that you have or have had that is not listed above.

DENTAL HISTORY

Reason for today's visit					
Former Dentist		City		State	
Date of Last Dental Visit		Date of Last Dental X-rays			

Do you have any dental issues that need to be addressed immediately?	❑ Yes ❑ No
If yes, please explain	
Have you ever had a negative dental experience?	❑ Yes ❑ No
Are you interested in facial cosmetics, ie. Botox, dermal fillers?	❑ Yes ❑ No

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Are you happy/ satisfied with your smile?	❑ Yes	❑ No
Would you like to discuss available options in dental cosmetics (smile makeovers, teeth whitening, white fillings)?	❑ Yes	❑ No
On a scale of 1-10, how would you rate your mouth's health/ condition?		

Do you have any of the following:

Clicking or popping jaw	❑ Yes	❑ No	Periodontal treatment	❑ Yes	❑ No
Sensitivity to cold/heat	❑ Yes	❑ No	Sensitivity when biting	❑ Yes	❑ No

FORM COMPLETION

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:		Date:	

IF PATIENT IS A MINOR

Form signed by:		Relationship to Patient:	