HUTTO DENTAL
Dr. Timothy J. Bulgerin
115 East Street, Suite B
Hutto, Texas 78634

PATIENT REGISTRATION

Patient's Name **Birth date** **Age** **Sex: M F**

Home Address	**City**	**State**	**Zip**

Home Phone # **Work Phone #** **YOUR cell phone #**	***Please Circle One:***	
Your Employer	Single, Married, Separated, Widow	**Your Soc Sec. # (is not necessary if paying at the time of service)**
Occupation		

Are you a full time student? ☐Yes ☐ No

If patient is minor we need: *Mother's Name & Birth date* *Father's Name & Birth date*

Person paying this bill **YOUR Driver's License Number**

Name of spouse (or parent if minor) **YOUR E-mail address**

Spouse's (or parent's) employer **Spouse's Soc. Sec. #** **Work phone #**

EMERGENCY INFORMATION

Name, Address, & Telephone of
A relative not living with you:

How did you hear about our office?

Reason for your visit today ?

DENTAL INSURANCE INFORMATION (Primary Carrier)	**If you have a dual insurance coverage, complete this for the second coverage (this office bills primary ins only)**
Insured's name DOB SS#	Insured's name DOB SS#
Insured's employer	Insured's employer
Insurance Co	Insurance Co
Insurance Co Address	Insurance Co Address
Phone #	Phone #
Group # Policy #	Group # Local #

Patient Signature (or Parent of Child) **Date** **Dentist's Signature**

DENTAL HISTORY

Please check any of the following that apply to you.

-Sensitivity (hot, cold, sweet) ☐
Where? UR LR UL LL
-Headaches, earaches, neck pain ☐
-Jaw joint pain ☐
-Teeth or fillings breaking ☐
-Grinding or clenching teeth ☐
-Bleeding, swollen or irritated gums ☐
-Loose, tipped or shifting teeth ☐
-Bad breath ☐

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

-Dentures ☐
-Partial dentures ☐
-Braces ☐
-Gum treatments ☐

Please share the following dates:

-Your last cleaning ___ / ___
-Your last oral cancer screening ___ / ___
-Your last complete X-Rays ___ / ___

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐

Do you smoke or use chewing tobacco? ☐
How much? For how long?

If I could change my smile, I would: ☐
-Make them whiter ☐
-Make them straighter ☐
-Close spaces ☐
-Replace black metal fillings with tooth colored restorations ☐
-Repair chipped teeth ☐
-Replace missing teeth ☐
-Replace old crowns that don't match ☐
-Have a smile makeover ☐

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit today?
_____

What is the most important thing to you about your future smile and dental health? _____

Please check any of the following that apply to you:

☐ AIDS	☐ Drug Addiction	☐ HIV Positive	☐ Rheumatic Fever
☐ Allergies (Seasonal)	☐ Emphysema	☐ Jaundice	☐ Rheumatism
☐ Anemia	☐ Excessive Bleeding	☐ Jaw Joint Pain	☐ Scarlet Fever
☐ Arthritis	☐ Fainting	☐ Kidney Disease	☐ Seizures
☐ Artificial Heart Valve	☐ Glaucoma	☐ Liver Disease	☐ Stomach Problems
☐ Artificial Joints	☐ Heart Conditions	☐ Low Blood Pressure	☐ Stroke
☐ Asthma	☐ Heart Lesions (Congenital)	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Blood Disease	☐ Heart Murmur	☐ Nervousness/Depression	☐ Tuberculosis
☐ Bruise Easily	☐ Heart Surgery	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hepatitis A	☐ Phen Fen (1 month +)	☐ Venereal Diseases
☐ Chemotherapy	☐ Hepatitis B	☐ Pregnant Currently	☐ Other
☐ Diabetes	☐ Hepatitis C	☐ Radiation (head/neck)	
☐ Dizziness	☐ High Blood Pressure	☐ Respiratory Problems	

Do you have any of the following drug allergies?

☐ Aspirin	☐Codeine
☐ Darvon	☐ Erythromycin
☐ Nitrous Oxide	☐ Valium
☐ Percodan	☐ Penicillin
☐ Local Anesthetic	☐ Other

Are you under a physician's care? What for?
_____

Are you taking any medications? What?
_____

Family Physician _____ **Phone Number** _____

Is there any other medical or dental information we should know about? _____

Patient Signature (Parent of Child) _____ Date _____ Dentist Signature _____