Wellington Circle Dental
616 Fellsway, 2nd Floor
Tel. 781-306-9644
www.wellngtonclrcledental.com
Patient Registration Form

Patient's Name: ____________________________________ Birthdate: __/__ /__ Sex: M F
Address:____ Apt#: _____ Martial Status: S M D
City:___________________________________ State:_______ Zip:_____________
SS#:____________________________ Home Phone:________________ Work Phone:________________
Cell Phone:_____________________ Email Address:____

Employer's Name:________________________________ Occupation:______________________________

If you are a full time student what school are you enrolled in?____________________________________
How did you hear about our office?____
Name(s) of any other family member(s) seen in our office:_______________________________________

Person Responsible for this Account____
Relationship to Patient: ☐Self* ☐Spouse ☐Parent/Guardian * If self; skip to Insurance Section
Name:____ Birthdate: __/__/__ Sex: M F
Does this person & patient reside in the same household? ☐YES ☐NO If NO please write info below
Address:______________________________________ Apt#_____ Home Phone:_____________________
City:__________________________ State:_____ Zip:_________ Work Phone:______________________
SS#: _______________________________
Employer's Name:________________________________ Occupation:______________________________

Is Patient Covered By Dental Insurance? ☐YES ☐NO
Employee's Name:____ Birthdate: __/__/__ Sex: M F
SS# or Subscriber Number (shown on card) ____
Employer's Name:________________________________ Insurance Company:_______________________
Relationship to patient: ☐Self ☐Spouse ☐Parent/Guardian Group#:_______________________
Is patient covered by another dental insurance? ☐YES ☐NO

Secondary Dental Insurance
Employee's Name:____ Birthdate: __/__/__ Sex: M F
SS# or Subscriber Number (shown on card) ____
Employer's Name:________________________________ Insurance Company:_______________________
Relationship to patient: ☐Self ☐Spouse ☐Parent/Guardian Group#:_______________________
Is patient covered by another dental insurance? ☐YES ☐NO

NOTE: Due to the constantly changing insurance rules and regulations, benefits and deductibles, we are only able to approximate your insurance balance. If your insurance pays more than expected you will be credited the difference. If your insurance company pays less than expected you will be billed the difference. Final responsibility for payment rests with the person responsible for your account.

Date: ___/__/__ Signature:___________________________ Relationship to Patient:________________

Medical Alert: ____________
Office Reminder

Medical and Health History

Patient Name: _______________________________________ Sex: M F Age:__________
☐ child ☐ adult ☐senior citizen ☐ teenager

Physician: _________________________________ Address: ____
Phone Number: (________) ___________________ Date of Last Physical: _______________________________

ARE YOU PRESENTLY IN GOOD HEALTH ☐YES ☐ NO

Are you currently under medical treatment? ☐YES ☐ NO
If yes, what?____
Are you taking any medication regularly? ☐YES ☐ NO
If yes, what?____
Have you been hospitalized in the past 2 years? ☐YES ☐ NO
If yes, for what? _______________________________________
Have you had any serious illness in the past 5 years? ☐YES ☐ NO
If yes, for what? _______________________________________

FEMALES PATIENTS ONLY

Are you pregnant? ☐YES ☐ NO
If yes, when is your delivery date? ________________________
Menstrual Problems? ☐YES ☐ NO
Are you taking birth control? ☐YES ☐ NO

DO YOU HAVE ANY OF THE FOLLOWING?

☐Y	☐ N	heart trouble	☐Y	☐ N	hepatitis/jaundice	☐Y	☐ N	communicable disease
☐Y	☐ N	heart mummers	☐Y	☐ N	liver disease	☐Y	☐ N	fainting problems
☐Y	☐ N	rheumatic fever	☐Y	☐ N	bleeding problem	☐Y	☐ N	dizziness
☐Y	☐ N	diabetes	☐Y	☐ N	venereal disease	☐Y	☐ N	epilepsy
☐Y	☐ N	low blood pressure	☐Y	☐ N	thyroid problems	☐Y	☐ N	hay fever
☐Y	☐ N	high blood pressure	☐Y	☐ N	ulcers	☐Y	☐ N	allergies
☐Y	☐ N	tuberculosis	☐Y	☐ N	HIV	☐Y	☐ N	sinus problems
☐Y	☐ N	asthma	☐Y	☐ N	AIDS	☐Y	☐ N	physical handicap
☐Y	☐ N	emphysema	☐Y	☐ N	arthritis	☐Y	☐ N	nervous disorders

Artificial prosthetic hip or joint replacement? ☐Y ☐ N
Have you ever been treated for cancer malignancy ☐Y ☐ N

HAVE YOU EVER HAD AN ALLERGIC REACTION OR ALLERGY TO ANY OF THE FOLLOWING?

☐ penicillin ☐ other antibiotics ☐ local anesthetics ☐ general anesthetics
☐ aspirin ☐ other drugs __________________________________

DENTAL HISTORY

Chief Dental Complaints ____
Previous Dentist: ___________________________ Address: ____
Phone: ____________________ Reason for leaving: ____
Approximately how long since your last dental visit? ____
Are you happy with your dental appearance? ____
Did you take any medications before your dental visit? ____
Last Cleaning: ☐Less than 6 months ☐ Over 6 months ☐ Over one year
Last Topical Fluoride: ☐Less than 6 months ☐ Over 6 months ☐ Over one year
Last complete set of **X-RAYS or PANORAMIC FILMS** ☐Less than 6 months ☐ Over 6 months ☐ Over one year

DO YOU HAVE ANY OF FOLLOWING?

☐Y	☐ N	sensitivity or pain while chewing	☐Y	☐ N	loose teeth
☐Y	☐ N	bleeding gums	☐Y	☐ N	bad breath
☐Y	☐ N	cracked or broken teeth	☐Y	☐ N	jaw pains
☐Y	☐ N	sores in mouth	☐Y	☐ N	oral habits
☐Y	☐ N	problem when flossing	☐Y	☐ N	tooth grinding
☐Y	☐ N	previous gum treatment	☐Y	☐ N	missing teeth
☐Y	☐ N	spaces between teeth	☐Y	☐ N	sensitivity to hot or cold
☐Y	☐ N	crowns or bridges	☐Y	☐ N	root canal treatment
☐Y	☐ N	problems during dental surgery	☐Y	☐ N	extreme apprehensiveness

COMMENTS; please describe any current medical or dental treatment:

Signature: ____ **Date:** ______________________