Wellington Circle Dental
616 Fellsway, 2nd Floor
Tel. 781-306-9644
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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:** _____