Paul J. Shires, D.D.S.
Keith A. Schmidt, D.D.S.
40 York Rd, Suite 220
Towson, MD 21204
410-296-6527

## PATIENT REGISTRATION

DATE_____________

Name__________________________________________________Soc.Sec.Num.______________________

Address __________________________________________________________________Zip_____________

Home Phone_____________________ Work Phone___________________ Cell Phone__________________

Email Address____________________________________________

Where do you prefer to have your appointment confirmed ? Home Work Cell Email

Birth date_____________ Age_____ Marital Status__________ Spouse's Name ______________________

Employer ___________________________________ Occupation (past if retired)______________________

Person Financially Responsible ____________________________Relationship to You__________________

In case of Emergency, Call _______________________________________Home Phone________________

Relationship_____________________________________________________Work Phone________________

Cell Phone_________________

Dental Insurance Company _______________________________Name of Policyholder_________________

Policyholder's DOB _____________Group #_____________________Contract #(S.S.)__________________

Employer _____________________________

Secondary Insurance Company ____________________________Name of Policyholder________________

Policyholder's DOB_____________ Group #____________________Contract # (S.S.)_________________

Employer _____________________________

Who may we thank for referring you? ____________________________________

## MEDICAL HISTORY

Physician _______________________________ Last Physical ______________ Phone _________________

Date of Last Appt. _______________ Reason ___________________________________________________

Do you have an existing illness? ____________ If so, please list ____________________________________

Please circle all that apply:

Arthritis
Artificial Joints, Pins/Plates
Kidney Problems, dialysis
Transplant _____________
Diabetes
Lupus/ Autoimmune Disease
Stomach Disorders
Stroke, Epilepsy, Seizure, Fainting
Respiratory Problems, Emphysema
TB, Sinus Problems
Thyroid Problems
Stent, Shunt

Heart Disease
High Blood Pressure
Chest Pain Angina
Heart Murmur
Mitral Valve Prolapse
Artificial Heart Valve
Pacemaker
Rheumatic Fever/Heart Disease
MRSA: location____________
Tattoos/ Piercing
Sleep Apnea
Told to Premedicate before Dental Appointments

Blood Transfusion
Hepatitis – liver disease
Anemia, Bleeding Problems
Splenectomy
Other Blood Problems
HIV+, ARC, AIDS
STD, VD, Herpes
Cancer
Chemotherapy
Radiation Therapy
Psychiatric Treatment

If under 26 yrs old : Have you been vaccinated for Human Papilloma virus (HPV)

Are you allergic or have you reacted adversely to any medication? ______ Latex? _____ Metals? ______

Nuts? _____ If so, please list _________________________________________________________________

Are you taking any prescription, birth control pills, or over-the-counter medications? _______ If so, please list_______________________________________________________________________________

____________________________________________________________(continue back of this page)

Have you ever had any operations or been hospitalized for any reason? ______ If so, please list

_______________________________________________________________________________

____________________________________________________________(continue back of this page)

Women: Is it possible that you are pregnant? ___________ Are you nursing? _______________________

Do you have history of headaches, earaches, neck or jaw pain? __________ How often? ______________

For how long? ___________________________________________________________________________

Do you or did you ever smoke or chew tobacco? ___________ For how many years? ________________

Are you interested in quitting? ______________________________________________________________

Have you ever had an adverse reaction to any dental procedures?_______ If so, please list ____________

_______________________________________________________________________________

Is there anything you would like to speak privately about? __________________________________________

## Dental History

What kind of water do you drink? Well? City? Filtered? Bottled?

Do you have any dental complaints? _______________________________________________________

When was your last dental visit? _____________ Reason ____________________________________

When was your last dental cleaning/exam? __________________________________________________

Do you have any teeth sensitive to hot, cold, sweets, or biting pressure? _____________________________

Do your gums bleed when you brush? ____________________ Floss? ___________________________

Do you have problems: eating bagels? ___chewing gum? ___ with food getting caught between teeth? ___

Have you ever wanted whiter teeth? _______________________________________________________

Are you dissatisfied with the appearance of your teeth? _____________________________________

Are you aware or have you been told that you clench or grind your teeth? __________________________

Do you or a family member: Snore ?______ Choke or Gasp for breath during sleep? _______________

Wake frequently ?________ Feel tired or fatigued ?____ Been advised to wear a CPAP? _____________

Do you have any loss, worn, or shifting teeth? _______ Has your bite changed in the past 5 years? ______

Do you have more than one bite? _________________________________________________________

Do you or any of your family members have a history of periodontal disease? ______________________

Have you had orthodontic treatment? ____ If so, how many years ago? ____ Do you have retainers? ____

How often do you brush? _______________________ Floss? _________________________________

Are you apprehensive about dental treatment? ______________________________________________

Do you prefer local anesthesia (numbing of your teeth) for fillings? _____________________________

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I hereby authorize the use of any of my medical and dental information, radiographs and/or photographs for the use in collaboration with other medical and dental professionals and in seminars, publications, or our website.

I understand my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services.

I understand I am financially responsible for payments in full of all accounts. By signing this statement, I agree to pay for services not paid, in whole or in part by my dental insurance carrier.

I am responsible to confirm insurance coverage for all treatments that I seek.

I attest to the accuracy of the information provided and will inform this office of any changes.

Patient's Signature ____________________________________________ Date _________________

Dentist _____________________________________________________ Date _________________