

Welcome! *The benefits of a healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we care for you!*

 GREGORY B. WRIGHT, DDS, PA
Metro (817) 481-7999



PATIENT REGISTRATION

NAME			I LIKE TO BE CALLED		
SPOUSE/PARENT'S NAME IF CHILD			DATE		
ADDRESS					
CITY		STATE	ZIP	EMAIL	
HOME PHONE		CELL PHONE		WORK PHONE	
BIRTHDATE	AGE	GENDER	M OR F	MARTIAL STATUS	
SOCIAL SECURITY NUMBER			WHO MAY WE THANK FOR REFERRING YOU?		
EMERGENCY CONTACT		CONTACT PHONE		RELATIONSHIP TO PATIENT	
IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE? Y OR N NAMES:				RELATIONSHIP TO PATIENT	

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME		
RELATIONSHIP TO PATIENT	SSN#	
ADDRESS		
CITY	STATE	ZIP
HOME PHONE	CELL	
EMAIL		

DENTAL INSURANCE

INSURANCE COMPANY	
INSURANCE COMPANY PHONE	
GROUP NO.	
EMPLOYEE	
DATE OF BIRTH	DATE EMPLOYED
YEARLY DEDUCTIBLE	
EMPLOYEE SS#	

ABOUT YOU

EMPLOYER	YRS EMPLOYED	
OCCUPATION		
BUSINESS ADDRESS		
CITY	STATE	ZIP
BUSINESS PHONE		
OTHER		

ABOUT YOUR SPOUSE

EMPLOYER	YRS EMPLOYED	
OCCUPATION		
BUSINESS ADDRESS		
CITY	STATE	ZIP
BUSINESS PHONE		
OTHER		

CONSENT

CONSENT FOR TREATMENT FOR _____
PLEASE PRINT PATIENT'S NAME

I attest that to the best of my knowledge the information provided is accurate and complete. Any changes in health status or medications will be reported to the Doctor at the next visit following the change. In addition I authorize the Doctor or his representative to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis and to develop proper treatment recommendations. I also authorize the Doctor to perform all forms of treatment, medication, and therapy that may be indicated, and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made in advance.

SIGNATURE _____ DATE _____

PATIENT PARENT GUARDIAN

(TURN OVER TO COMPLETE)

MEDICAL HISTORY

GENERAL HEALTH EXCELLENT GOOD FAIR POOR

NAME OF PHYSICIAN _____

PHONE No. _____

HAVE YOU BEEN UNDER MEDICAL CARE IN THE LAST 2 YEARS? YES NO If YES, EXPLAIN _____

LAST COMPLETE PHYSICAL _____

LAST BLOOD PRESSURE CHECK _____

BLOOD PRESSURE _____

LIST ALL MEDICATIONS YOU TAKE _____

HAVE YOU BEEN TREATED FOR:

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) YES NO

ANEMIA YES NO

ARTHRITIS YES NO

ASTHMA YES NO

CANCER YES NO

WHAT TYPE _____

RADIATION TREATMENT. YES NO

CHRONIC COUGH YES NO

DIABETES. YES NO

DRY MOUTH (XEROSTOMIA) YES NO

EPILEPSY. YES NO

GLAUCOMA. YES NO

HEPATITIS OR JAUNDICE. YES NO

HEART DISEASE. YES NO

ABNORMAL BLOOD PRESSURE. YES NO

CONGENITAL HEART DEFECTS. YES NO

MURMUR YES NO

RHEUMATIC FEVER YES NO

STROKE YES NO

JOINT REPLACEMENT. YES NO

MULTIPLE SCLEROSIS YES NO

OSTEOPOROSIS DRUGS YES NO

SINUS TROUBLES/ALLERGIES YES NO

TUBERCULOSIS. YES NO

ULCERS YES NO

VD (SYPHILIS, GONORRHEA) YES NO

ARE YOU ALLERGIC TO: PENICILLIN CODEINE LOCAL ANESTHETICS LATEX OTHER MEDICINES: LIST OTHERS: _____

ARE YOU SUBJECT TO PROLONGED BLEEDING YES NO

FAINTING SPELLS OR DIZZY SPELLS YES NO

DO YOU HAVE ANY CONDITION NOT LISTED YES NO

IF YES, EXPLAIN _____

(WOMEN) ARE YOU PREGNANT YES NO HOW LONG? _____

TAKING BIRTH CONTROL YES NO NURSING YES NO

DENTAL HISTORY

DATE OF LAST DENTAL VISIT _____

DENTIST'S NAME _____

PHONE No. _____

DID YOU HAVE X-RAYS TAKEN _____

YES NO

DATE OF LAST DENTAL CLEANING _____

DO YOU WEAR FULL OR PARTIAL DENTURES _____

YES NO

IF YES, HOW OLD ARE THEY _____

HAVE YOU HAD ALL OF YOUR TEETH X-RAYED IN THE PAST 3 YEARS YES NO

ARE YOU DISSATISFIED WITH THE APPEARANCE OF YOUR TEETH OR SMILE YES NO

WOULD YOU CHANGE YOUR SMILE IF YOUR COULD YES NO

DO YOU SNORE OR HAVE SLEEP APNEA YES NO

HAVE YOU HAD ORTHODONTIC TREATMENT YES NO

DO YOU CLENCH OR GRIND YOUR TEETH DURING THE DAY OR NIGHT YES NO

HAVE YOU EVER HAD A PAIN IN YOUR JAW JOINT OR YOUR FACE OR AROUND YOUR EAR YES NO

DOES YOUR JAW JOINT CLICK OR POP YES NO

DO YOU HAVE DIFFICULTY OPENING YOUR MOUTH WIDELY YES NO

DO YOU HAVE AN UNPLEASANT ODOR, OR TASTE IN YOUR MOUTH YES NO

DO YOUR GUMS BLEED WHEN BRUSHING YES NO

HAVE YOU EVER BEEN DIAGNOSED WITH GUM DISEASE YES NO

IS YOUR MOUTH OR TEETH SENSITIVE TO: PRESSURE YES NO COLD YES NO HOT. YES NO

DOES FOOD CATCH BETWEEN YOUR TEETH YES NO

DO YOU HAVE DIFFICULTY GETTING NUMB FOR DENTAL TREATMENT YES NO

PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT FOR THE DOCTOR TO KNOW (ANY SPECIAL CONCERNS) _____

