RURAL HEALTH GROUP
healthcare that fits your family

Interpretation/Translation Services Needed ☐

Dental Registration Form

Today's Date:_____

Patient's Name:_____ Date Of Birth:_____

Parent's Name *(If Under 18)*: _____ Patient Social Security #: _____

Address: _____

City: _____ State:_____ Zip: _____

Phone #:_____ Alt. Phone #:_____

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Emergency Contact: _____ Emergency Phone #: _____

Household Size:_____ **Annual Household Income**:
Household includes everyone living under the same roof sharing/pooling resources.

☐ $0-$10,000 ☐ $10,001-$15,000 ☐ $15,001-$20,000 ☐ $20,001-$25,000
☐ $25,001-$30,000 ☐ $30,001-$35,000 ☐ $35,001-$40,000 ☐ $40,001-$45,000
☐ $45,001-$50,000 ☐ $50,001-$55,000 ☐ $55,001-$60,000 ☐ $60,001-$65,000
☐ $65,001-$70,000 ☐ $70,001-$75,000 ☐ $75,001-$80,000 ☐ More than $80,000

Sex:
☐ Male
☐ Female
☐ Transgender

Veteran:
☐ Yes
☐ No

Homeless:
☐ Yes
☐ No

Migrant or Seasonal Farm Worker:
☐ Yes
☐ No

Race:
☐ African American/Black
☐ American Indian/Native American
☐ Asian
☐ Caucasian/White
☐ Other: _____

Ethnicity:
☐ Hispanic
☐ Non-Hispanic

Primary Language:
☐ English
☐ Spanish
☐ Other: _____

Pharmacy:
☐ CVS
☐ Drugco
☐ Drum's
☐ Futrell – Jackson
☐ Futrell – Rich Square
☐ Kerr Drug
☐ Littleton Pharmacy
☐ McDowell's
☐ RHG at Hollister
☐ RHG at Norlina
☐ Rite Aid (Eckerds)
☐ Spears
☐ Wal-Mart
☐ Walgreens
☐ Other: _____

Pharmacy City:
☐ Ahoskie
☐ Enfield
☐ Henderson
☐ Henrico
☐ Hollister
☐ Jackson
☐ Littleton
☐ Norlina
☐ Rich Square
☐ Roanoke Rapids
☐ Rocky Mount
☐ Scotland Neck
☐ Tarboro
☐ Warrenton
☐ Whitakers
☐ Other: _____

Insurance:
☐ Medicaid
☐ Medicare
☐ Private
☐ Self Pay (None)
☐ Sliding Fee

Please provide your insurance card to the receptionist for copying.

RESPONSIBLE PARTY INFORMATION

Person Financially Responsible For Acct: _____

Relationship to patient: ☐ Self ☐ Parent/Guardian ☐ Spouse ☐ Other: _____

Address: _____

City: _____ State:_____ Zip: _____

Phone #:_____ Social Security #: _____

Employer:_____ Employer Phone #: _____

PATIENT MEDICAL HISTORY

Healthcare provider: _____ Office Phone: _____ Last Exam: _____

1.	Are you under medical treatment now?	☐ Yes	☐ No	☐ Unsure
2.	Have you ever been hospitalized for any surgical operation or serious illness? List *(include dates)*: _____	☐ Yes	☐ No	☐ Unsure
3.	Do you smoke or use tobacco/snuff?	☐ Yes	☐ No	☐ Unsure
4.	Do you drink alcoholic beverages?	☐ Yes	☐ No	☐ Unsure
5.	Do you use illegal substances (cocaine, meph, etc.)	☐ Yes	☐ No	☐ Unsure
6.	Are you wearing contact lenses?	☐ Yes	☐ No	☐ Unsure
7.	Are you allergic to any medications or foods? List: _____	☐ Yes	☐ No	☐ Unsure
8.	Have you ever had an adverse reaction to any medications?	☐ Yes	☐ No	☐ Unsure

Women Only

9.	Are you pregnant or think you may be pregnant?	☐ Yes	☐ No	☐ Unsure
10.	Are you nursing?	☐ Yes	☐ No	☐ Unsure
11.	Are you taking birth control pills or using other method of birth control?	☐ Yes	☐ No	☐ Unsure

Are you taking any medication(s) including any herbal or over the counter medications? If yes, list all medications:

_____

_____

Health History: Please indicate if any of the following conditions apply to you and/or anyone in your family (living or dead).

You	*Family*		*You*	*Family*		*You*	*Family*	
☐	☐	Anemia	☐	☐	Epilepsy Convulsions/Seizures	☐	☐	Nervous Problems
☐	☐	Angina	☐	☐	Fainting	☐	☐	Osteoporosis
☐	☐	Anxiety	☐	☐	Frequently Tired	☐	☐	Pacemaker/Defibrillator
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Psychiatric Care
☐	☐	Artificial Heart Valves, Joints, etc.	☐	☐	Hay Fever/Allergies	☐	☐	Radiation Treatment
☐	☐	Asthma	☐	☐	Headaches	☐	☐	Recent Weight Loss
☐	☐	Back Problems	☐	☐	Hearing Loss	☐	☐	Respiratory (Breathing) Problems
☐	☐	Bleeding Abnormally	☐	☐	Heart Attack	☐	☐	Rheumatic Fever
☐	☐	Blood Disease	☐	☐	Heart Disease	☐	☐	Sexually Transmitted Disease
☐	☐	Cancer	☐	☐	Heart Murmur	☐	☐	Shortness of Breath
☐	☐	Chest Pain	☐	☐	Heart Problems	☐	☐	Stomach Ulcers/Troubles
☐	☐	Chronic Cough	☐	☐	Hemophilia	☐	☐	Stroke
☐	☐	Chronic Constipation	☐	☐	Hepatitis Jaundice/Liver Disease	☐	☐	Substance Abuse
☐	☐	Chronic Diarrhea	☐	☐	Hernia Repair	☐	☐	Swollen Ankles
☐	☐	Circulatory Problems	☐	☐	High Blood Pressure	☐	☐	Swollen Neck Gland
☐	☐	Congenital Heart Lesions	☐	☐	HIV/AIDS	☐	☐	Ulcer (External, etc.)
☐	☐	COPD/Chronic Lung Disease	☐	☐	Irregular Heartbeat/Atrial Fibrillation	☐	☐	Thyroid Problems
☐	☐	Current Infection(s)	☐	☐	Joint Replacement or Implant	☐	☐	Tuberculosis
☐	☐	Deep Vein Thrombosis	☐	☐	Kidney/Bladder Urinary Problems	☐	☐	Vision Problems
☐	☐	Depression	☐	☐	Leukemia	☐	☐	Other: _____
☐	☐	Diabetes	☐	☐	Low Blood Pressure			
☐	☐	Emphysema	☐	☐	Mitral Valve Prolapse			

PATIENT DENTAL HISTORY

Check if the answer is "Yes".

☐	1. Do your gums bleed while brushing or flossing?	☐	8. Do you have frequent headaches?
☐	2. Are your teeth sensitive to hot or cold liquids/foods?	☐	9. Do you clench or grind your teeth?
☐	3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	10. Do you bite your lips or cheeks frequently?
☐	4. Do you feel pain to any of your teeth?	☐	11. Have you ever had any difficulty with extractions in the past?
☐	5. Do you have any sores or lumps in or near your mouth?		
☐	6. Have you had any head, neck, or jaw injuries?	☐	12. Have you had any orthodontic work?
	7. Have you ever experienced any of the following problems in your jaw?	☐	13. Have you ever had prolonged bleeding following extractions or periodontal cleaning (SRP)?
☐	A. Clicking		
☐	B. Pain (Joint, Ear, Side of Face)	☐	14. Have you ever had instruction on the correct method of brushing your teeth?
☐	C. Difficulty in opening or closing		
☐	D. Difficulty in chewing	☐	15. Have you ever had instructions on the care of your gums?

Signature: _____ Date: _____