MARC R. TOMLINSON, D.D.S.
104 West 4th Street, Suite E
Aberdeen, Washington 98520

PATIENT REGISTRATION

Please Print and Answer All Questions

GENERAL DENTISTRY
Phone (360) 532-7512

PATIENT ____ Birthdate ____ /____ /____
Last Name First Name M.I. Nickname, or I preferred to be called by

Phone: Home ( ) ______________ Billing Address ______________________________
Address City State Zip

Work ( ) ______________ Street Address ______________________________
Address City State Zip

Cell Phone ( ) ______________ Social Security No.______________ [ ] Male [ ] Female [ ] Single [ ] Married Best time to call________

Employer and Work No. ______________________________ Spouse's Name______________

Spouse's SS No. ______________ Spouse's Employer and Work No.______________________

Person responsible for account [ ] Patient Other ______________________ Responsible parties SS#______________

[ ] Own or [ ] Rent Home Hobbies ______________________________

Who to contact in case of emergency (Name and Phone Number) ______________________________

DENTAL INSURANCE YES________ NO__________ **DSHS** YES__________ NO __________

PRIMARY INSURANCE	SECONDARY INSURANCE
Insured Name ______________________	Insured Name ______________________
SS# ______________ Birthday __________	SS# ______________ Birthday __________
Employer ______________ Work No. __________	Employer ______________ Work No. __________
Insurance Co. ______________ Group # __________	Insurance Co. ______________ Group# __________
Insurance Address ______________________	Insurance Address ______________________
Insured relationship to patient [ ] Self [ ] Spouse [ ] Child [ ] Other	Insured relationship to patient [ ] Self [ ] Spouse [ ] Child [ ] Other

Referred to this office by ______________________________

There are many medical situations which can affect or be affected by the procedures or drugs used for dentistry. Therefore, please fill out the following carefully. Thank you.

DATE OF LAST MEDICAL EXAM______________ Physician's Name ______________________ Phone ______________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING – INDICATE WITH (X)

_ HIV-Aids
_ Allergies to drugs
_ Allergies to anesthetics
_ Any heart ailments
_ High blood pressure
_ Pacemaker
_ Joint Replacement
_ Heart Valve Replacement
_ Neurological problems
_ Radiation treatments
_ Excessive bleeding from cut or extractions
_ Anemia or blood problems
_ Arthritis
_ Fainting or dizzy spells
_ Asthma
_ Hay fever or allergies in general
_ Diabetes
_ Kidney problems
_ Liver problems or hepatitis
_ Malignancies
_ Psychiatric care/emotional problems
_ Rheumatic fever
_ Sinus problems
_ Epilepsy
_ Stroke
_ Thyroid
_ Eye disorders
_ Tonsillitis
_ Tuberculosis
_ Ulcer or colitis
_ Pregnancy,
Due date __________
_ Venereal disease
_ Prostate

PLEASE: describe any current medical treatment, including drugs, vitamins/OTC Meds, impending operations, pregnancies or other information Dr. Tomlinson should be aware of:______________________________

Are you taking drugs for: High blood pressure________ Cortisone or steroids________ Blood thinners________ Sedatives or tranquilizers__________

Other ______________________________

Date of last dental exam______________ Previous Dentist ______________ Any previous major dental treatment [ ] YES [ ] NO When ?__________

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING – INDICATE WITH (X)

_ Teeth sensitive to cold, heat, sweets or pressure
_ Bleeding gums. How long? ____________
_ Food impaction
_ Clenching or grinding
_ Burning of tongue
_ Swelling or lumps in mouth
_ Frequent blisters on lips or mouth
_ Pain around ear
_ Unusual sounds in ear while eating
_ Bad breath
_ Unpleasant taste
_ Unfavorable dental experience
_ Complications from extractions
_ Periodontal treatment
_ Orthodontic treament
_ Mouth breathing
_ Oral habits, i.e., fingernail biting, cheek biting, etc.
_ Cigarettes, pipe or cigar smoking
_ Texture of toothbrush __________
_ Frequency of brushing __________
_ Dental floss
_ Inter dental stimulators
_ Water jet device
_ Disclosing tablets or solution
_ Fluoride supplements__________

I hereby certify that the above information is true and correct. SIGNED:______________________________ Date:__________
Patient – Parent or Guardian (if under 18)