PATIENT REGISTRATION

Patient Information

First Name:____ Last Name:_____________________________________ Middle Initial:__________

Nickname: ____ E-mail Address:____

Mailing Address:____ Street Address:____

City:____ State:__________________________________ Zip:______________________

Home Phone:______________________________ Mobile Phone:_____________________________ Work Phone:__________________________

Birth Date:________________________________ Age:____________________ Social Security #:____________________________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment status: ☐Not Employed ☐Full Time ☐Part Time ☐Retired Name of Employer: ____

Student Status: ☐ Full Time ☐ Part Time Name of School if Student:____

Previous Dentist Name:____ Date of Last Visit:______________________________

Preferred Pharmacy Name and Location:____

Parent or Legal Guardian (if patient is minor)

First Name:____ Last Name:____ Middle Initial:_____

Mailing Address:____ Street Address:____

City:____ State:____________________ Zip Code:_________________________

Home Phone:_____________________________ Mobile Phone:______________________________ Work Phone:____________________________

Birth Date:_________________ Social Security #:__________________________ Relationship to patient:____________________________________

Primary and Secondary Insurance Information

Name of Primary Insured:_____________________________________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security #:_________________________________ Insured Birth Date:____________________________

Employer:____ Insured ID#____________________________________

Name of Secondary Insured:__________________________________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security #______________________________________ Insured Birth Date:__________________________

Employer:____ Insured ID#_______________________________________

Please provide a copy of the insurance card

HEALTH HISTORY

PATIENT NAME: ____ DATE:___________________________

As required by law, our office adheres to written policies to protect privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

Do your gums bleed when you brush or floss? ☐Yes ☐No
Are your teeth sensitive to cold, hot, sweets or pressure? ☐Yes ☐No
Do you brux or grind your teeth? ☐Yes ☐No
Do you have sores or ulcers in your mouth? ☐Yes ☐No
Have you had any problems associated with previous dental treatment? ☐Yes ☐No
Are you currently experiencing dental pain or discomfort? ☐Yes ☐No
What is the reason for your dental visit today? ____
Date of your last dental exam? ______________________ Date of last dental x-rays? ____________________________________
What was done at the time? ____

MEDICAL INFORMATION

Are you now under the care of a physician? ☐Yes ☐No
If yes, what condition is being treated?____
Physician's Name: ____ Phone Number: ____________________________________
Date of last physical exam? _________________________
Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐Yes ☐No
If yes, explain?____
Are you taking or have you recently taken any prescription or over the counter medications? ☐Yes ☐No
If yes, please list all medications and dosage? ____
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____

Are you on a special diet? ☐Yes ☐No If yes, explain____
Do you use tobacco? ☐Yes ☐No If yes, what type and how often? ____
Do you us controlled substances (drugs)? ☐Yes ☐No If yes, what type and how often?_______________________________
Do you drink alcoholic beverages? ☐Yes ☐No If yes, how much in the last 24 hours? ________________________________
Do you take, or have you taken Phen-Fen or Redux? ☐Yes ☐No If yes, date last taken? ______________________________
Do you take, or have you taken Fosamax, Boniva, Actonel,
or any other medication containing bisphosphonates? ☐Yes ☐No If yes, date last taken? ___________________________

WOMEN ONLY Are you: Pregnant? ☐Yes ☐No If yes, number of weeks?______________ Nursing? ☐Yes ☐No
Taking birth control bills or hormonal replacement? ☐Yes ☐No

Health History (continued)

Patient Name:____Date:_____________________

ALLERGIES – Are you allergic to any of the following :
☐ Aspirin ☐ Penicillin ☐ Other Antibiotics ☐ Codeine ☐ Other Narcotics ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Acrylic ☐ Metal ☐ Latex (rubber) ☐ Iodine ☐ Hay fever/seasonal ☐ Animals ☐ Food ☐ Other

If yes, please explain:____

Artificial (prosthetic) heart valve ☐Yes ☐No Previous infective endocarditis ☐Yes ☐No
Congenital Heart Disease (CHD):
Damaged valves in transplanted heart ☐Yes ☐No Unrepaired, cyanotic CHD ☐Yes ☐No
Repaired (completely) in last 6 months ☐Yes ☐No Repaired CHD with residual defects ☐Yes ☐No
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐Yes ☐No If yes, Date: ____________________
If yes, have you had any complications? ____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐Yes ☐No
Name of physician or dentist making recommendation __________________________________Phone: ______________________

Do you have any disease, condition or problem not listed above that you think we should know about? ☐Yes ☐No
If yes, please explain____

Do you have or have you had any of the following:

AIDS/HIV+	☐Yes☐No	Epilepsey or Seizures	☐Yes☐No	Liver Disease	☐Yes☐No
Alzheimer's Disease	☐Yes☐No	Excessive Bleeding	☐Yes☐No	Low Blood Pressure	☐Yes☐No
Anemia	☐Yes☐No	Excessive Thirst	☐Yes☐No	Lung Disease	☐Yes☐No
Angina	☐Yes☐No	Fainting Spells/Dizziness	☐Yes☐No	Osteoporosis	☐Yes☐No
Arthritis/Gout	☐Yes☐No	Frequent Cough	☐Yes☐No	Psychiatric Care	☐Yes☐No
Asthma	☐Yes☐No	Frequent Diarrhea	☐Yes☐No	Radiation Treatments	☐Yes☐No
Blood Disease	☐Yes☐No	Genital Herpes	☐Yes☐No	Rheumatic Fever	☐Yes☐No
Blood Transfusion	☐Yes☐No	Glaucoma	☐Yes☐No	Scarlet Fever	☐Yes☐No
Breathing Problems	☐Yes☐No	Hay Fever	☐Yes☐No	Shingles	☐Yes☐No
Bruise Easily	☐Yes☐No	Heart Attack/Failure	☐Yes☐No	Sickle Cell Disease	☐Yes☐No
Cancer	☐Yes☐No	Heart Murmur	☐Yes☐No	Sinus Trouble	☐Yes☐No
Chemotherapy	☐Yes☐No	Heart Pacemaker	☐Yes☐No	Stomach Disease	☐Yes☐No
Chest Pains	☐Yes☐No	Heart Trouble/Disease	☐Yes☐No	Stoke	☐Yes☐No
Convulsions	☐Yes☐No	Hepatitis A, B or C	☐Yes☐No	Thyroid Disease	☐Yes☐No
Diabetes	☐Yes☐No	Herpes	☐Yes☐No	Tuberculosis	☐Yes☐No
Drug Addition	☐Yes☐No	High Blood Pressure	☐Yes☐No	Ulcers	☐Yes☐No
Easily Winded	☐Yes☐No	High Cholesterol	☐Yes☐No	Venereal Disease	☐Yes☐No
Emphysema	☐Yes ☐No	Kidney Problems	☐Yes☐No	Yellow Jaundice	☐Yes☐No

Have you ever had any serious illness not listed above? ☐Yes☐No____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the information in this patient registration and health history form and that the information given on these forms are accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth in this form have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:____Date:________________________

FOR COMPLETION BY DENTIST

Comments:____

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