Patient Registration – Medical/Dental History

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Patient Information

PATIENT'S NAME: Last_____ First_____ Middle Initial____
Preferred Name/Nickname_____ Today's Date_____
Soc. Sec. #_____ SEX: M F Birthdate_____
If Minor, Parent's or Guardian's Name(s)_____
Reason for Today's Visit___ _____
Who may we thank for referring you to our practice?_____

Responsible Party Information

NAME: Last_____ First_____ Middle Initial____
Relationship to Patient_____ Soc. Sec. #_____
SEX: M F Marital Status_____ Birthdate_____
ADDRESS Street_____ Apt#_____
City_____ State_____ Zip_____
Home Phone_____ Cell Phone_____
Work Phone_____ Email_____
Driver's License #_____ State Issued_____
Employer_____ Occupation_____ Years Employed_____

Emergency Contact Information

Name_____ Relationship_____
Address_____
Home Phone_____ Cell Phone_____
Work Phone_____ Email_____

It is very important that we know your Medical and Dental history. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to fill out this form.

DENTAL HISTORY *Please Circle "Yes" or "No" and describe where necessary.*

Do you have a specific dental problem? .....Yes No
Describe_____
Do you have dental examinations on a routine basis? .....Yes No
Approx. date of last visit_____
Date of last full mouth x-rays (14 films, or a Panoramic) .....Yes No

Have you had any periodontal (gum) treatments? .....Yes No
Describe_____
Do you floss your teeth on a routine basis? How often?_____ .....Yes No
Do your gums ever bleed, feel tender, or irritated? .....Yes No
Describe_____
Are your teeth sensitive to hot, cold, sweets, or chewing? .....Yes No
Describe_____
Are you happy with your smile? Why or why not?_____ .....Yes No
Do you ever hear clicking or popping, or feel discomfort in your jaw? .....Yes No
Do you clench or grind your teeth?.....Yes No
Describe_____
Are you apprehensive about dental treatment? If yes, why? .....Yes No
Do you smoke or use tobacco products? Describe frequency_____ ...Yes No
Name, address, phone of previous dentist_____
_____

MEDICAL HISTORY *Please Circle "Yes" or "No" and describe where necessary.*

Are you currently under the care of a physician? .....Yes No
Why?_____
Physician's Name_____ Phone_____
Have you ever had a major operation? .....Yes No
Describe_____
Have you ever had a serious injury to your head or neck? .....Yes No
Describe_____
Are you taking any medications, pills or drugs? .....Yes No
Please list_____

Are you allergic to any medications or substances? Please check below .....Yes No
❑ Asprin ❑ Penicillin/Amoxicillin ❑ Erythromycin ❑ Codeine
❑ Nitrous Oxide ❑ Local Anesthetic ❑ Latex
❑ Other_____

Are you taking, or have you taken bisphosphonate drugs? Please check below .....Yes No
❑ Fosamax ❑ Boniva ❑ Actonel ❑ Skelid ❑ Didronel
❑ IV Aredia ❑ IV Zometa

Women (Please check): ❑ Pregnant ❑ Trying to get pregnant
❑ Nursing ❑ Taking oral contraceptives

*Do you or have you ever had any of the following? Please check appropriate boxes. *If yes to any of these starred conditions, please call prior to your appointment as pre-medication may be necessary.*

	Y	N		Y	N		Y	N
Heart Disease/Surgery*	__	__	Shortness of Breath	__	__	Liver Disease	__	__
Heart Murmur*	__	__	Frequent Cough	__	__	Kidney Problems	__	__
Mitral Valve Prolapse*	__	__	Hay Fever	__	__	Renal Dialysis	__	__
Rheumatic Fever*	__	__	Sinus Trouble	__	__	Thyroid Disease	__	__
Artificial Heart Valve*	__	__	Asthma	__	__	Parathyroid Disease	__	__
Artificial Joint*	__	__	Bloody Sputum	__	__	Arthritis	__	__
Ever taken Fen-Phen?*	__	__	Emphysema	__	__	Hepatitis B or C	__	__
Heart Pacemaker	__	__	Tuberculosis	__	__	Hepatitis A (infectious)	__	__
Irregular Heart Beat	__	__	Cancer	__	__	Night Sweats	__	__
Angina/Chest Pain	__	__	Radiation Treatments	__	__	Drug Dependency	__	__
Heart Attack/Failure	__	__	Chemotherapy	__	__	Alcoholism	__	__
Congenital Heart Disorder	__	__	Stomach/Intestinal Disease	__	__	Tattoos/Body Piercing	__	__
High Blood Pressure	__	__	Ulcers/Colitis	__	__	Stroke	__	__
Bacterial Endocarditis	__	__	Rapid Weight Gain/Loss	__	__	Epilepsy/Seizures	__	__
Blood Disease	__	__	Frequent Diarrhea	__	__	Fainting/Dizziness	__	__
Anemia	__	__	Diabetes	__	__	Glaucoma	__	__
Excessive Bleeding	__	__	Excessive Thirst	__	__	Psychiatric Care	__	__
Sickle Cell Disease	__	__	Hypoglycemia	__	__	Nervousness/Anxiety	__	__
Hemophilia	__	__	HIV/AIDS	__	__	Alzheimer's Disease	__	__
Leukemia	__	__	Venereal Disease	__	__	Migraines/Headaches	__	__
Recent Blood Transfusion	__	__	Genital Herpes	__	__	Auto-immune Disease	__	__
Swelling of Limbs	__	__	Oral Herpes/Fever Blisters	__	__	Need Pre-medication?	__	__
Lung Disease	__	__	Yellow Jaundice	__	__			

Have you ever had any other serious illness not listed above? If so, please describe

_____

To the best of my knowledge, all the preceding answers are correct. If there are any changes to my health status or medications, I shall inform the dentist and staff at my next appointment.

PATIENT SIGNATURE (PARENT OR GUARDIAN)

X_____ Date_____

Reviewed by Doctor (signature)_____ Date_____

MEDICAL UPDATES

Date	Changes	Patient Sig.	Doctor Sig.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____