DENTAL REGISTRATION AND HISTORY

Date ___/ ___/_____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____

Last Name First Name MI

Address _____ Email _____

City _____ State_____ Zip_____

❑ M ❑ F Age_____ Birthdate___/___ /_____ ❑ Married ❑ Widowed ❑Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Who referred you to our office? _____

Emergency Contact _____ Phone (____) _____

DENTAL HISTORY

Reason for today's visit_____ Date of last dental care ___/___/_____

Former dentist _____ Date of last dental X-rays ___/___/_____

Address _____

Check ( ) if you have had problems with any of the following:

❑ Bad breath
❑ Bleeding gums
❑ Clicking or popping jaw
❑ Food collection between teeth
❑ Grinding teeth
❑ Loose teeth or broken fillings
❑ Periodontal treatment
❑ Sensitivity to cold
❑ Sensitivity to hot
❑ Sensitivity to sweets
❑ Sensitivity when biting
❑ Sores or growths in the mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit___/___/_____
Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).
❑ Y ❑ N

Have you had any serious illnesses or operations? ❑ Y ❑ N
If yes, describe _____
Have you ever had a blood transfusion? ❑ Y ❑ N
If yes, give approximate date(s) _____
(Women)
Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check ( ) if you have or have had any of the following:

❑ Anemia	❑ Cortisone Treatments	❑ Hepatitis	❑ Scarlet Fever
❑ Arthritis, Rheumatism	❑ Cough, Persistent	❑ High Blood Pressure	❑ Shortness of Breath
❑ Artificial Heart Valves	❑ Cough Up Blood	❑ HIV/AIDS	❑ Skin Rash
❑ Artificial Joints	❑ Diabetes	❑ Jaw Pain	❑ Stroke
❑ Asthma	❑ Epilepsy	❑ Kidney Disease	❑ Swelling of Feet or Ankles
❑ Back Problems	❑ Fainting	❑ Liver Disease	❑ Thyroid Problems
❑ Blood Disease	❑ Glaucoma	❑ Mitral Valve Prolapse	❑ Tobacco Habit
❑ Cancer	❑ Headaches	❑ Pacemaker	❑ Tonsillitis
❑ Chemical Dependency	❑ Heart Murmur	❑ Radiation Treatment	❑ Tuberculosis
❑ Chemotherapy	❑ Heart Problems	❑ Respiratory Disease	❑ Ulcer
❑ Circulatory Problems	❑ Hemophilia	❑ Rheumatic Fever	❑ Venereal Disease

MEDICATIONS:
List any medications you are currently taking:
_____
Pharmacy Name _____
Phone (___) _____

ALLERGIES:

❑ Aspirin	❑ Sulfa
❑ Barbiturates (Sleeping Pills)	❑ Latex _____
❑ Codeine	❑ Other _____
❑ Local Anesthetic	_____
❑ Penicillin	

SIGNATURE:
The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ___/___/_____ Signature _____