Patient Registration Form

As required by law, our office adheres to written policies and procedures to protect the 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 may be asked about your responses to this questionnaire. This information is vital to allow us to provide appropriate care for you. We do not use this information to discriminate.

First Name:_____ MI:_____ Last Name: _____

Preferred Name:_____ Date of Birth:_____ Gender:_____

Financially Responsible Party:_____ Self Other: _____

Address:_____

City:_____ State:_____ Zip Code: _____

Phone Number:_____ Email:_____

Preferred method of contact for reminders (please circle): Phone Text Email

Dental Insurance Company (if applicable): _____

Policy Holder Name: _____

Policy Holder Date of Birth:_____ Policy Holder ID Number: _____

Policy Holder Employer: _____

Policy Group Number: _____

Secondary Insurance (if applicable): _____

Policy Holder Name: _____

Policy Holder Date of Birth:_____ Policy Holder ID Number: _____

Policy Holder Employer: _____

Policy Group Number: _____

How did you hear about our office? _____

Why have you come to the dentist today? _____

When did you last have your teeth cleaned? _____

Is there anything we should know prior to treatment or anything we can do to make you more comfortable? _____

Medical History

Emergency Contact Name and Relationship: _____

Emergency Contact Phone: _____

Do you have any of the following:

Active Tuberculosis? _____YES _____NO

Persistent cough greater than 3 weeks duration? _____YES _____NO

Cough that produces blood? _____YES _____NO

Been exposed to anyone with Tuberculosis? _____YES _____NO

(Continued on back of form)

Are you now under the care of a Physician? _____YES _____NO
Physician Name and Phone: _____
Physician Address: _____
Are you in good health?_____YES _____NO
Has there been any change in your general health within the past year? _____YES _____NO
If YES, please explain: _____
Date of last Physical Exam (if known): _____
Have you had a serious illness, operation or been hospitalized in the last 5 years?___YES ___NO
If YES, please explain: _____
Please list any prescriptions or over-the-counter medicines you currently take (including vitamins, herbs, supplements): _____
_____
Do you wear contact lenses? _____YES _____NO
Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? ____YES ____NO
If so, date?_____ Any complications? _____
Are you taking or scheduled to begin taking alendronate (Fosamax), risedronate (Actonel) or denosumab (Prolia) for osteoporosis or Paget's disease? _____YES _____NO
Have you been treated with (or plan to be treated with) IV bisphosphonates (Aredia or Zomeda) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? _____YES _____NO
Do you use controlled substances? _____YES _____NO
Do you use tobacco (smoking, snuff, chew), e-cigarettes or vaping products? ____YES ____NO
If yes, please specify: _____
Are you interested in quitting? _____YES _____MAYBE _____NO

WOMEN ONLY:
Are you pregnant? _____YES _____NO If YES, number of weeks: _____
Are you taking birth control pills or hormone replacements? _____YES _____NO
Are you nursing?_____YES _____NO

PLEASE INDICATE IF YOU <u>ARE ALLERGIC OR HAVE HAD A REACTION</u> TO ANY OF THE FOLLOWING:

__Local Anesthetics
__Aspirin
__Penicillin or other antibiotics
__Barbiturates, sedatives or sleeping pills
__Sulfa drugs
__Codeine or other narcotics
__Metals
__Latex
__Iodine
__Hay fever/seasonal allergies
__Animals
__Food
__Other: _____

PLEASE INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING HEART PROBLEMS:

__Artificial (prosthetic) heart valve
__Previous infective endocarditis
__Damaged valves in transplanted heart
__Congenital heart disease (CHD)
__Unrepaired, cyanotic CHD
__Defect repaired in the last six months
__Repaired CHD with residual defects

PLEASE INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

___Cardiovascular disease
___Angina
___Arteriosclerosis
___Congestive heart failure
___Damaged heart valves
___Heart attack
___Heart murmur
___Low blood pressure
___High blood pressure
___Other congenital defects
___Mitral valve prolapse
___Pacemaker
___Rheumatic fever
___Rheumatic heart disease
___Abnormal bleeding
___Anemia
___Blood transfusion (date:_____)
___Hemophilia
___AIDS or HIV
___Arthritis
___Autoimmune disease
___Rheumatoid arthritis
___SLE (Lupus)
___Asthma
___Bronchitis
___Emphysema
___Sinus trouble
___Tuberculosis
___Cancer, Chemotherapy or Radiation treatment
___Chest pain upon exertion
___Chronic pain
___Diabetes type I or II
___Eating disorder
___Malnutrition
___Gastrointestinal disease
___G.E. reflux or persistent heartburn
___Thyroid problems
___Stroke
___Glaucoma
___Hepatitis, jaundice or liver disease
___Epilepsy
___Fainting spells or seizures
___Neurological disorders
Specify: _____
___Sleep disorders
___Mental health disorders
Specify: _____
___Recurrent infections
Specify: _____
___Kidney problems
___Night sweats
___Osteoporosis
___Persistent swollen glands in neck
___Severe headaches or migraines
___Severe/rapid weight loss
___Sexually transmitted disease
___Excessive urination

Do you have any disease, condition or problem not listed above that you think we should know about? _____YES _____NO

If YES, please explain: _____

_____

(Continued on back of form)

PREMEDICATION

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? _____YES _____NO

If YES, name and phone number of physician: _____

I certify that the information given on this form is accurate to the best of my knowledge. I understand the importance of a truthful health history and that my dentist and staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of the 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: _____

REVIEW OF NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to review the Notice of Privacy Practices and understand that I may request a copy of this policy at any time.

(IF APPLICABLE) I authorize the release of any of my dental information including proposed treatment plans, procedure fees, and dental history to the following individuals:

Name:_____Relationship: _____

Name:_____Relationship: _____

Signature of Patient/Legal Guardian:_____Date: _____