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 (if under 18): _____________________________

Mailing Address:____

City:________________________________State:________________Zip Code: __________________

Phone Number:_________________________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: ____
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
(specify): ___________________________
___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
Specify: _______________
___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, indicate reason, name and phone number of physician: ________________________

SLEEP SCREENING

Have you ever been diagnosed with obstructive sleep apnea (OSA)? _____YES _____NO

Are you currently being treated for OSA? _____YES _____NO

Are you aware of a family history of OSA? _____YES _____NO

Are you aware of clenching or grinding your teeth at night? _____YES _____NO

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.

I authorize the release of any of my dental information including proposed treatment plans, procedure fees, and dental history to the following individuals (please leave this section blank and sign below if there is no one you would like information released to):

Name:_________________________________Relationship: ___________________________________

Name:_________________________________Relationship: ___________________________________

Signature of Patient/Legal Guardian:_________________________________Date: ________________