REGISTRATION

Date _____

Patient's Full Name_____ Birthdate _____

Home Address_____

City_____ Zip _____ Phone _____

Email_____

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

Emergency Contact/Spouse _____

If Patient is a Child, Parent's Name _____

(If Patient is a Child, Parent's Employment)

Employed By _____ Occupation_____

Business Address _____ Work Phone _____

Spouse Employed By _____ Occupation_____

Business Address _____ Work Phone _____

PATIENT HEALTH QUESTIONNAIRE

Physician's Name _____

Are you under a physician's care now?. . . . . ☐ Yes ☐ No

Do you require a premedication prior to dental treatment?. . . . . ☐ Yes ☐ No

Have you been in the hospital during the past two years? . . . . . ☐ Yes ☐ No

Do you use tobacco products?. . . . . ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

☐ Anemia	☐ Congenital Heart Defect	☐ Heart Surgery	☐ Pacemaker
☐ Arthritis	☐ Cortisone Treatment	☐ Hemophilia	☐ Psychiatric Treatment
☐ Artificial Heart Valve	☐ Cough, Persistent	☐ Hepatitis/Type_____	☐ Radiation Treatment
☐ Artificial Joint/Screws/Pins	☐ Diabetes/Type_____	☐ High/Low Blood Pressure	☐ Respiratory Disease
☐ Artificial Bone Replacement	☐ Insulin Dependent?_____	☐ HIV/AIDS	☐ Rheumatic Fever
☐ Asthma	☐ Epilepsy	☐ Herpes	☐ Sinus Problems
☐ Back Problems	☐ Emphysema	☐ Jaw Pain	☐ Shingles
☐ Bleeding/Blood Clotting Problems	☐ Fainting	☐ Kidney Disease	☐ Skin Rash
☐ Blood Disease/Transfusion	☐ Fibromyalgia	☐ Liver Disease	☐ Stroke
☐ Breast Implants	☐ Glaucoma	☐ Lupus	☐ Thyroid Problem
☐ Cancer	☐ Headaches/Migraines	☐ Mitral Valve Prolapse	☐ Tuberculosis/Active or Latent
☐ Chemical Dependency	☐ Heart Attack	☐ MRSA	☐ Ulcer
☐ Circulatory Problems	☐ Heart Problems	☐ Organ Transplant	☐ Venereal Disease

MEDICATIONS:

List medications, pills or drugs you are currently taking: _____

_____

_____

ALLERGIES: Please Mark (X) if you have any of the following:

☐ Aspirin ☐ Barbiturates (Sleeping Pills) ☐ Penicillin ☐ Sulfa ☐ Latex ☐ Metals

☐ Local Anesthetic ☐ Codeine ☐ Other: _____

Have you had any disease, condition, problem, or surgery not listed on the previous page that could possibly affect your dental treatment? If so, please list them: _____

Reason for today's visit _____

Former Dentist_____Tel_____Last X-Ray Date _____

Last Cleaning_____ Last Dental Visit _____

Do you feel pain? ☐ Yes ☐ No If yes, please describe _____

Do you feel numbness, swelling or any other sensitivity? ☐ Yes ☐ No If yes, please explain_____

_____

The above information is accurate and complete to the best of my knowledge. I will not hold the 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_____

OFFICE POLICIES

All patients must give a 48 hour notice for cancelled appointments. If you are late or fail your appointment, you may be dismissed from our practice.

For our state-program patients:

We verify your insurance before each appointment. If it is inactive or you are not eligible, we will make every attempt to contact you. If we cannot reach you, we will cancel your appointment without notice.

I understand the above and have agreed to its contents. (If the patient is a minor, parent/guardian is required to be present.)

Name: _____

Signature: _____

Date: _____