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Adult Registration and Medical History

Your complete oral health is our main concern. Communication is key to helping us give you a happy, healthy smile. We therefore ask that you complete this form in its entirety.

1 ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: _____ SS #: _____

Home Address: _____
APT / CONDO #

CITY STATE ZIP
 Single Married Divorced Widowed Separated

Home #: (____) _____ Pager/Cell #: _____

Work #: (____) _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where and when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Last Visit Date: _____

2 SPOUSE INFORMATION

Name: _____

Employer: _____

Work #: (____) _____ Ext: _____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account:

Work #: (____) _____ Ext: _____ Home #: (____) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Work #: (____) _____ Home #: (____) _____

4 MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

Are you currently under the care of a physician? Yes No

Please Explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY *continued*

Your current physical health is: Good Fair Poor

Are you taking any prescription, over-the-counter, or supplement drugs?
 Yes No

Please list each one: _____

Do you smoke or use tobacco in any other form? Yes No

Have you ever taken Fosamax, Actonel, Boniva, or any other bisphosphonate? Yes No

Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems? (Please circle option that applies)

- | | |
|---------------------------------------|----------------------------------|
| Y N Anemia/Radiation Treatment | Y N Hemophilia/Abnormal Bleeding |
| Y N Artificial Bones/Joints/Valves | Y N Hepatitis |
| Y N Arthritis | Y N High/Low Blood Pressure |
| Y N Asthma | Y N HIV+/AIDS |
| Y N Blood Transfusion | Y N Hospitalized for Any Reason |
| Y N Cancer/Chemotherapy | Y N Kidney Problems |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Diabetes | Y N Psychiatric Problems |
| Y N Difficulty Breathing | Y N Rheumatic/Scarlet Fever |
| Y N Drug/Alcohol Abuse | Y N Severe/Frequent Headaches |
| Y N Emphysema/Glaucoma | Y N Shingles |
| Y N Epilepsy/Seizures/Fainting Spells | Y N Sickle Cell Disease/Traits |
| Y N Fever Blisters/Herpes | Y N Sinus Problems |
| Y N Heart Attack/Stroke | Y N Tuberculosis (TB) |
| Y N Heart Murmur | Y N Ulcers/Colitis |
| Y N Heart Surgery/Pacemaker | Y N Venereal Disease |

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

- | | | |
|------------------------|--------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Penicillin |
| Y N Codeine | Y N Jewelry/Metals | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Latex | Y N Other |

Please list any other drugs/materials that you are allergic to: _____

5 DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Have you ever had periodontal disease? Yes No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? Hard Medium Soft

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____

Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

We appreciate your effort to fill out this complete form. It will ensure that we can provide the most effective care possible. Please do not hesitate to ask if you have any questions. We are here for you.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

2. Date: _____ Comments: _____ Signature: _____

3. Date: _____ Comments: _____ Signature: _____