Center for Cosmetic and Sedation Dentistry

PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE ALL FORMS OF THE FOLLOWING CONFIDENTIAL INFORMATION

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA.

TODAY'S DATE: _____

NAME:_____ NAME I LIKE TO BE CALLED: _____

MAILING ADDRESS: _____CITY:_____ ZIP:_____

STREET ADDRESS: _____CITY:_____ ZIP:_____

BIRTHDAY: _____ MARITAL STATUS:_____ SS#: _____ EMAIL: _____

HOME #: (____)_____ WORK#:(____)_____ EXT:____ CELL#: (____)_____

OCCUPATION: _____ EMPLOYER: _____

SPOUSE'S OR PARENT'S NAME: _____ BIRTHDAY: _____ SS#: _____

SPOUSE'S/PARENT'S OCCUPATION: _____ SPOUSE'S/PARENT'S EMPLOYER: _____

BEST CONTACT PHONE #: _____

PERSON RESPONSIBLE FOR ACCOUNT

□ CHECK IF SAME AS ABOVE; PROCEED TO NEXT SECTION

NAME: _____ SS#: _____

ADDRESS: _____ CITY: _____ ZIP: _____

RELATIONSHIP TO PATIENT: _____ BIRTHDATE: _____

EMPLOYER: _____ WORK #: (____)_____

DENTAL INSURANCE

EMPLOYEE NAME: _____MEM ID#: _____ BIRTHDATE: _____

INSURANCE COMPANY: _____ INSURANCE: (____)_____

EMPLOYER: _____ GROUP#: _____

GETTING TO KNOW YOU

PLEASE LIST THE MEMBERS OF YOUR FAMILY THAT ARE PATIENTS IN OUR OFFICE: _____

_____

HOW DID YOU HEAR ABOUT OUR OFFICE? □YELLOW PAGES □WEBSITE □FRIEND: _____

□NEWSPAPER □SIGN □TV □BILLBOARD □MAILER □MAGAZINE □FACEBOOK □GOOGLE

OTHER: _____

PERSON TO CONTACT IN CASE OF EMERGENCY (NOT LIVING WITH YOU):

NAME: _____ PHONE: (_____)_____

ADDRESS: _____ CITY:_____ STATE:_____ ZIP: _____

HEALTH HISTORY - ANSWER ALL QUESTIONS

NAME: ______________________________________

Are you currently under the care of a physician?- **Y** **N**

Physician's Name:____Phone:____

Are you taking ANY prescriptions or over-the-counter medications? **(IF YES, PLEASE LIST ALL MEDICATIONS)** **Y** **N**

List:____

Are you allergic to any medications or substances (including latex)?- **Y** **N**

If yes, explain: ____

Is there any history of alcohol or chemical dependency that may affect the care we provide for you? - - - - - - - - - - - - - - - - **Y** **N**

If yes, explain: ____

Are you taking or have you ever taken Bisphosphonates for osteoporosis or any other medical conditions?- - - - - - - - - - - **Y** **N**

If yes, circle all that apply: Fosamax Actonel Boniva Skelid Didronel Aredia Zometa

Have you ever been or are you currently being treated for a mental illness?- **Y** **N**

If yes, explain: ____

HEART DISEASE - **Y** **N** If yes, explain: ____________________________________

LUNG DISEASE- **Y** **N** If yes, explain: ____________________________________

BLEEDING OR BLOOD DISORDER- - - - - - - - - - - - **Y** **N** If yes, explain: ____________________________________

DIABETES- **Y** **N** If yes: Type I Type II Last HBA1C :________________________

LIVER DISEASE- **Y** **N** If yes, explain: ____________________________________

ARTIFICIAL JOINT/IMPLANT - - - - - - - - - - - - - - - **Y** **N** If yes, explain: ____________________________________

SMOKE/VAPE/CHEW TOBACCO- - - - - - - - - - - - - **Y** **N** If yes, how much per day ______________________________

RECREATIONAL DRUGS- - - - - - - - - - - - - - - - - - - **Y** **N** If yes, explain: ____________________________________

SEIZURES/EPILEPSY- **Y** **N**

HIGH BLOOD PRESSURE - - - - - - - - - - - - - - - - - - **Y** **N** RADIATION OR CHEMOTHERAPY- **Y** **N**

SINUS OR NASAL PROBLEM - - - - - - - - - - - - - - - **Y** **N** HIV POSITIVE- **Y** **N**

KIDNEY DISEASE - **Y** **N** STOMACH ULCERS OR COLITIS- **Y** **N**

GLAUCOMA - **Y** **N** ARTHRITIS- **Y** **N**

SLEEP APNEA - **Y** **N** THYROID DISEASE - **Y** **N**

Do you have any other disease, condition, or problem not listed that you think the doctor should know about?- - - - - - - - **Y** **N**

If yes, explain: ____

FOR WOMEN ONLY

Are you on any form of birth control?- - - - - - - - **Y** **N** Are you pregnant or nursing?- **Y** **N**

DENTAL HISTORY

Are you having pain or discomfort at this time?- - - - - - - - Y N Explain: ______________________________________

Have you ever had a bad dental experience?- - - - - - - - Y N Explain: ______________________________________

Are you happy with the appearance of your smile?- - - - - Y N Explain: ______________________________________

Is there anything else about going to the dentist that bothers you ? ______________________________________

Please rate your level of dental anxiety: HIGH AVERAGE LOW NONE

I affirm that the above information is correct to the best of my knowledge. If I have any changes in my health history, or if my medicines change, I will inform my dentist at the next appointment without fail. I authorize the doctor/assistant to take x-rays, study models, photographs, or any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform all recommended treatment, appropriate medications, and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose to employ assistance as deemed fit to provide recommended treatment.

Patient (or Guardian) Signature: ____ **Date:** ____________________