Patient Registration information

PLEASE PRINT

Patient Name: _____

First *MI* *Last*

Address: _____City:_____ State_____ Zip: _____

Phone: *(HM)* _____ *(WK)* _____ext.___ *(Cell)* _____

Email Address: _____**Date Of Birth:** _ _ /_ _ /_ _ _ _

Sex: M / F **Status:** ☐ Married ☐ Single ☐ Other _____

Medical History

Health problems that you may have, or medications that you are taking, could have an affect on the dental treatment that you will receive. Thank you for answering the following questions.

●Primary care Physician _____Hospital _____ Phone# _____

●Do you need to take an antibiotic before having your teeth cleaned? _____

●Have you had:

_____ Subacute Bacterial Endocarditis , _____Artificial Heart Valve,

_____Heart Transplant _____Congenital Heart Defect (excluding Mitral Valve Prolapse)

____ Other Cardiac Conditions:_____

●Do you have any prosthetics or artificial joints? _____

●Do you have osteoporosis or osteopenia _____ Do you take any bone density medications (ie: Fosomax) _____

●Do you have any allergies to any of the following: ____Local Anesthetics ____Latex ____Aspirin ____Penicillin _____ Acrylic ____Metal, ____Other (please explain)_____

●Have you ever had an Anaphylactic reaction? No / Yes _____

●Please list all medical conditions & medications you take for them. Use the reverse side if you need more space.

	Medications	**Reason for taking**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

●Do you or have you used tobacco products No / Yes. If Yes how much weekly intake_____

●Do you consume alcoholic beverages No / Yes. If Yes how much weekly intake_____

Please check all that apply

Blood Disorders
- ☐ Excessive Bleeding
- ☐ Hemophilia

Heart
- ☐ Heart Attack/Failure
- ☐ Chest Pains
- ☐ Angina
- ☐ Heart Pace Maker
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure

Infections DX
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Tuberculosis
- ☐ AIDS/HIV Positive

Cancer
- ☐ Type_____
  Date_____
  Treatment:
  _____

Diabetic
- ☐ Insulin controlled
- ☐ Diet controlled

Liver Diseases
- ☐ Type_____
  Date_____
  Treatment:
  _____

Kidney Diseases
- ☐ Type_____
  Date_____
  Treatment:
  _____
- ☐ Renal Dialysis

Neurological
- ☐ Psychological Disorders
- ☐ Nervous Disorders
- ☐ Epilepsy or Seizures
- ☐ Stroke date: _____

Pulmonary
- ☐ Asthma
- ☐ Emphysema
- ☐ Frequent Cough
- ☐ Respiratory Problems

Pregnancy
- ☐ Pregnancy *Due date:*_____

Other -

_____

_____

_____

X_____DATE:_____