Family Dental Health

Patient Registration Paperwork

Patient Personal Information

Title		Nickname		Birth Date	
Last, First				Marital Status	
Address				Home #	
				Cell #	
City, State, Zip				Emergency Contact	
Email				Student	
Health Care Guardian Name				School Name	
Health Care Guardian Phone #				Referral Type	

Age	
Sex	
Work #	
Drive Lic	
Emergency Phone #	
SSN	

Person responsible/guarantor for paying bills

Title		Nickname		Birth Date	
Last, First				Marital Status	
Address				Home #	
				Cell #	
City, State, Zip				SSN	
Email					

Age	
Sex	
Work #	
Drive Lic	

Do you have Primary Dental Insurance? __ Yes __ No

Group No/Name			
Insurance Name			
Phone #			
Employer Name			
Subscriber Last, First			
Subscriber Address			
City, State, Zip			
Relationship to Patient		Birth Date	
Subscriber ID			

Do you have Secondary Dental Insurance? __ Yes __ No

Group No/Name			
Insurance Name			
Phone #			
Employer Name			
Subscriber Last, First			
Subscriber Address			
City, State, Zip			
Relationship to Patient		Birth Date	
Subscriber ID			

Patient Medical Information

Are you

- ☐ Y ☐ N Taking blood thinners?
- ☐ Y ☐ N Allergic to penicillin
- ☐ Y ☐ N Allergic to clindamycin
- ☐ Y ☐ N Allergic to latex
- ☐ Y ☐ N Using tobacco products
- ☐ Y ☐ N Sensitive to anesthetics
- ☐ Y ☐ N Easily bruised
- ☐ Y ☐ N Using recreational drugs

Have you ever had:

- ☐ Y ☐ N A pacemaker
- ☐ Y ☐ N Bleeding problems
- ☐ Y ☐ N Organ transplant
- ☐ Y ☐ N Compromised immune system
- ☐ Y ☐ N Damaged heart valve
- ☐ Y ☐ N Prosthetic heart valve
- ☐ Y ☐ N History of rheumatic fever

Have you ever experienced

- ☐ Y ☐ N Chest pain (angina)
- ☐ Y ☐ N Shortness of breath
- ☐ Y ☐ N Persistent cough
- ☐ Y ☐ N Blood in your cough
- ☐ Y ☐ N Difficulty swallowing
- ☐ Y ☐ N Frequent nausea/vomiting
- ☐ Y ☐ N Dizziness or fainting spells
- ☐ Y ☐ N Ringing in ears
- ☐ Y ☐ N Chronic headaches

Have you ever had

- ☐ Y ☐ N Heart disease
- ☐ Y ☐ N Heart attack
- ☐ Y ☐ N High blood pressure
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Congestive Heart Failure
- ☐ Y ☐ N COPD
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Tuberculosis (TB)
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N Liver disease
- ☐ Y ☐ N Kidney Disease
- ☐ Y ☐ N Type I Diabetes
- ☐ Y ☐ N Type II Diabetes
- ☐ Y ☐ N HIV/AIDS
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N Cancer
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Radiation Therapy

Women Only

- ☐ Y ☐ N Chance of pregnancy?
- ☐ Y ☐ N Nursing?

Bone Related

- ☐ Y ☐ N Had osteoporosis?
- ☐ Y ☐ N Taken any bisphosphonate?
- ☐ Y ☐ N Taken risedronate/Actonel?
- ☐ Y ☐ N Taken alendronate/Fosamax
- ☐ Y ☐ N Taken ibandronate/Boniva
- ☐ Y ☐ N Taken zoledronic acid/Reclast
- ☐ Y ☐ N Taken pamidronate/Aredia
- ☐ Y ☐ N Taken etidronate/Didronel

☐ Y ☐ N Congenital heart abnormality

☐ Y ☐ N Low blood pressure

☐ Y ☐ N High cholesterol

Additional Comments

Dental Questionnaire

Dental Questionnaire

Do you experience dry mouth or a lack of saliva (spit)? _____

What of the following do you use regularly? _____

Sleep Apnea

Have you ever had a sleep study? _____

Have you ever been diagnosed with sleep apnea? _____

Do you snore? _____

Have you been prescribed a CPAP? _____

If so, describe how often you wear it. _____

Have you been prescribed a dental sleep device? _____

If so, describe how often you wear it. _____

Grinding/TMJ

Have you been prescribed a nightguard? _____

If so, describe how often you wear it? _____

TMJ issues? _____

If so, describe the issues. _____

Do you grind or clench your teeth? _____

If so, describe when you notice it. _____

Medical Questionnaire

Emergency Contact

Emergency contact name _____

Emergency contact phone _____

Emergency contact relationship to patient _____

General

Do you have a regular physician? _____

If so, what is his/her name? _____

If so, what is his/her phone number? _____

Year of last visit? _____

Are you presently being treated for an illness or injury? _____

If so, please describe. _____

Have you ever been hospitalized?	
If so, please list reasons.	
Are you currently undergoing cancer treatment?	
If so, please describe	
Allergies	
Are you allergic to any medications?	
If so, please list:	
List any other allergies you may have.	
Have you ever had a serious allergic reaction of any type?	
Medicines	
Have you been prescribed any medications (including birth control)?	
If so, please list:	
Are you taking all of the medicines you have been prescribed as directed?	
List any over-the counter medicines you take regularly.	
List any vitamins or herbal supplements you take regularly.	
Premed	
Have you ever been told that you require antibiotics before seeing the dentist?	
If so, what was the reason?	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**

Dentist Signature **Date**