PatellaDENTAL

REGISTRATION & HISTORY

Name _____

Street Address _____

Mailing Address _____

City_____ **State** _____ **Zip**_____

Home Phone_____**Work Phone**_____

Cell Phone _____

Email Address_____

Date of birth _____

Present age _____

Single ____

Married ____

Widowed ____

Divorced ____

Separated ____

How would you prefer to be contacted for Appointment reminders and confirmations? **□Text or Email** **□Both** **□Phone Call Only**

How did you hear about our practice?_____

Date of last dental treatment _____

Dental service received _____

How often do you brush your teeth? _____

How often do you floss? _____

Do you use a hard or soft toothbrush? _____

Are you unhappy with the appearance of your teeth? _____

Do your gums bleed when chewing or brushing?_____

Have you ever had periodontal (gum) treatments, or "deep cleanings?" _____

Do you clench or grind your teeth? _____

Do you feel discomfort in your jaw joint or ear when chewing? _____

Do you gag easily? _____

Do you have any sores or ulcers in your mouth? _____

Do you feel you will eventually lose all your teeth even with proper care? _____

Do any members of your family, including your parents, wear dentures? _____

Are you deeply concerned about the finances required to return your mouth to excellent dental health? _____

Do you get frustrated because you always have something to be treated or repaired when you visit the dentist? _____

Do you avoid dental treatment due to anxiety? _____

Have you had poor experiences with dentistry in the past? _____

What is the primary reason for your dental visit today?

_____

If you could change anything about your teeth, what would you change?

_____

How long do you plan to keep your teeth? _____

Please add anything you feel is important. _____

_____

Past Surgeries: _____

Are you now or have you recently been under the care of a physician? _____ **Why?** _____

Have you had a serious illness, operation, or been hospitalized in the past 5 years? _____

If so, what was the illness or problem?_____

Are you taking any medication, prescribed or self-administered? _____

If so, what medications?_____

Has a physician recommended that you take antibiotics prior to your dental treatment? _____

Have you ever taken Boniva, Fosamax, Actonel, or any other medication containing bisphosphonates? (Often prescribed for Osteoporosis or Paget's Disease)_____

List of medications you have allergies to: _____

Name of Physician_____ **Date of last medical exam** _____

Do you have or have you ever had any of the following? (Check yes or no)

	YES	NO
Ulcers	☐	☐
Rheumatic Fever	☐	☐
Heart Disease	☐	☐
Heart Valve Problems	☐	☐
Cancer/Chemo/Radiation Treatment	☐	☐
High or Low Blood Pressure	☐	☐
Stroke	☐	☐
Kidney or Liver Trouble	☐	☐
Congestive Heart Failure	☐	☐
Arthritis	☐	☐
Diabetes	☐	☐
Tuberculosis	☐	☐
Malignancies (Cancer)	☐	☐
Asthma	☐	☐
Hay fever, Allergies, or Hives	☐	☐
Hepatitis, Jaundice, or Liver Disease	☐	☐
Epilepsy, Seizures, Convulsions	☐	☐
Difficulties in Hearing or Eye Disease	☐	☐

	YES	NO
Alcohol. If so, how much?_____	☐	☐
Do you smoke? If so, packs per day_____	☐	☐
Angina (Chest Pain)	☐	☐
Severe Headaches	☐	☐
Sinus Trouble	☐	☐
Excessive or Prolonged Bleeding	☐	☐
Anemia or Blood Disorder	☐	☐
AIDS or HIV Infection	☐	☐
Pregnant? If so, what month?_____	☐	☐
Trying to become pregnant?	☐	☐
History of Anesthesia Problem	☐	☐
Adverse effects or reaction to:		
Penicillin	☐	☐
Local Anesthetic ("Novocaine," etc.)	☐	☐
Latex	☐	☐
Any Other Drug	☐	☐
Psychiatric or Nervous Disorder	☐	☐

Social Security Number_____

Patient (or Guardian) Employed by_____

Present Position and/or Department _____

Spouse Employed by _____

Present Position and/or Department _____

In case of emergency, notify: _____**Phone:** _____

Who will pay this account? _____

The above medical history is true to the best of my knowledge and I consent to routine procedures deemed to be necessary for diagnosis and treatment.

Signature of Patient or Guardian_____**Date**_____