

PATIENT REGISTRATION

NAME _____ AGE _____ MARITAL STATUS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ WORK PHONE (____) _____ CELL PHONE (____) _____

E MAIL ADDRESS _____

SOC. SECURITY NUMBER _____ DATE OF BIRTH _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____

WHO REFERRED YOU TO US? _____

OCCUPATION _____ EMPLOYER NAME & ADDRESS: _____

STREET _____ CITY _____ STATE _____ ZIP _____

IF STUDENT, WHAT COLLEGE? _____

DO YOU HAVE DENTAL INSURANCE? YES _____ NO _____

NAME OF DENTAL INSURANCE PLAN _____ GROUP NUMBER _____

DENTAL PLAN SUBSCRIBER NAME & DATE OF BIRTH _____

DENTAL PLAN SUBSCRIBER NUMBER _____

PERSON TO BE BILLED (IF OTHER THAN YOURSELF): NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

MEDICAL AND DENTAL HISTORY (Please circle your answers)

- 1. Do you have any medical problems? YES NO
- 2. Have you had any serious illnesses or operations? YES NO
- 3. Are you taking any drugs or medicines? YES NO If yes, please list below***
- 4. Are you allergic to any drugs or medicines? YES NO If yes, please list below***
- 5. Are you pregnant? YES NO
- 6. **Please check** any conditions you have had:

- | | | |
|------------------------|------------------------------|---------------------|
| HEART ATTACK | ARTIFICIAL JOINTS | OSTEOPOROSIS |
| ANGINA | OSTEOARTHRITIS | MULTIPLE MYELOMA |
| HEART MURMUR | RHEUMATOID ARTHRITIS | PAGET'S DISEASE |
| MITRAL VALVE PROLAPSE | DIABETES | CANCER |
| RHEUMATIC FEVER | SYSTEMIC LUPUS ERYTHEMATOSIS | PROSTATE CANCER |
| ARTIFICIAL HEART VALVE | KIDNEY PROBLEMS | BREAST CANCER |
| BYPASS SURGERY | DIALYSIS | LIVER PROBLEMS |
| CARDIOVASCULAR STENT | HYDROCEPHALY | HEPATITIS |
| HEART PACEMAKER | ARTIFICIAL SHUNT | PROLONGED BLEEDING |
| LUNG PROBLEMS | ASTHMA | HIGH BLOOD PRESSURE |
| FAINTING SPELLS | AIDS OR HIV INFECTION | |
| | EPILEPSY | |

7. Have you **ever** taken any of the following BRAND NAME or Generic drugs? YES NO

- | | | |
|------------------------|---------------------------|----------------------------|
| FOSAMAX or Aledronate | DIDRONEL or Etidronate | BONEFOS or Clodronate |
| ACTONEL or Risedronate | ZOMETA or Zoledronic Acid | SKELID or Tiludronate |
| BONIVA or Ibandronate | AREDIA or Pamidronate | RECLAST or Zoledronic Acid |
| ATELVIA or Risedronate | PROLIA or Denosumab | XGEVA or Denosumab |

- 8. Do you smoke or use smokeless tobacco? YES NO
- 9. Do you floss daily? YES NO
- 10. Are you currently having dental problems? YES NO

***List any medications to which you are allergic: _____

***List any medications you are currently taking: _____

DATE _____ PATIENT SIGNATURE _____