Patient Registration and History

Patient Information **Cetronia Dental**

First Name ______________________ Last Name _________________________ MI____ Title_____

Preferred Name _________________ Is Patient the Policy Holder ? Yes No

Address____ City_____________ Zip_______

Birthdate_______________ Sex: Male Female Marital Status_________________

SS#/Patient ID ________________________ Email ____

Home Phone ( )________ - ____________ Cell ( )________ - ____________Work ( )_______ - _______ ext ____

Patient Employer________________________ Occupation______________________

Employer Address ____

Spouse Name _______________________________ Phone ( )________ - ____________ Birthdate______________

Spouse Employer ____

Preferred Pharmacy ___________________________ Phone ( )________ - ____________

Previous Dentist ______________________________ Phone ( )________ - ____________

Emergency Contact ____________________________ Phone ( )________ - ____________

How did you hear about our office/ referring patient? ____

Dental Insurance

Patients Relationship to Insured Self Spouse Child Other

Name of Insured ___________________________________ Social Security # __________________ Birthdate ___________

Insured Employer ____

Insurance Company ___________________________ Group #______________ ID# ____________________

Insurance Company Address ____ Phone ( ) _____ - ________

City, State, Zip ____

Dental History

Reason for today's visit ____
Date of last dental visit ________________________ Date of last dental X-rays ____________________
Place a mark on "yes" or "no" to indicate if you had any of the following:

Bad Breath	Yes	No	Fingernail biting	Yes	No	Loose Teeth or broken fillings	Yes	No
Bleeding gums	Yes	No	Food collection between teeth	Yes	No	Mouth breathing	Yes	No
Blisters on lips or mouth	Yes	No	Clenching teeth	Yes	No	Orthodontic treatment	Yes	No
Burning sensation on tongue	Yes	No	Grinding teeth	Yes	No	Periodontal treatment	Yes	No
Tobacco products	Yes	No	Gums swollen or tender	Yes	No	Sensitivity to hot/cold	Yes	No
Clicking or popping jaw	Yes	No	Jaw pain	Yes	No	Sensitivity to sweets	Yes	No
Dry mouth	Yes	No	Lips or cheek biting	Yes	No	Sensitivity when biting	Yes	No

How often do you floss? ________________ How often do you brush? ________________ How often do you Waterpik?________________

Health History

Patient Name:

Physicians Name______________________________ Date of Last Visit ____________________________

Are you now or have you recently been under a physicians care? Yes No

Reason: ____

Have you ever been hospitalized or had a serious illness? Yes No

Explain____

Have you ever used a biphosphate medication? Yes No

Common brand names are Fosamax, Actonel, Zometa, Prolia, Boniva

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? Yes No

These include combinations of Ionimin, Adipex, Fastin (brand names of phenetamine), Pondimin (fenfluramine) and Redux (dexfenfluramine)

Do you require premedication for dental appointments? Yes No

Name of Antibiotic and dosage ____

AIDS/HIV	Yes	No	Epilepsy	Yes	No	Radiation Treatment	Yes	No
Alzheimer's disease	Yes	No	Fainting or Dizziness	Yes	No	Respiratory Disease	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No	Rheumatic Fever	Yes	No
Arthritis, Rheumatism	Yes	No	Headaches	Yes	No	Scarlet Fever	Yes	No
Artificial Joints	Yes	No	Hepatitis Type_____	Yes	No	Shingles	Yes	No
Artificial Heart Valves	Yes	No	Heart Murmur	Yes	No	Shortness of Breath	Yes	No
Asthma	Yes	No	Heart Problems	Yes	No	Sinus Trouble	Yes	No
Back Problems	Yes	No	Herpes	Yes	No	Skin Cancer	Yes	No
Bleeding (prolonged)	Yes	No	High Blood Pressure	Yes	No	Special Diet	Yes	No
Blood Disease	Yes	No	Jaundice	Yes	No	Swollen Feet or Ankles	Yes	No
Blood Transfusion	Yes	No	Jaw Pain	Yes	No	Swollen Neck Glands	Yes	No
Cancer	Yes	No	Kidney Disease	Yes	No	Stroke	Yes	No
Chemical Dependency	Yes	No	Leukemia	Yes	No	Thyroid Problems	Yes	No
Chemotherapy	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Chest pain	Yes	No	Low Blood Pressure	Yes	No	Tumor or growth	Yes	No
Circulatory Problems	Yes	No	Mitral Valve Prolapse	Yes	No	Ulcer	Yes	No
Congenital Heart Disorder	Yes	No	Nervous Problems	Yes	No	Venereal Disease	Yes	No
Cortisone Treatments	Yes	No	Osteoporosis	Yes	No	Weight loss, Recent	Yes	No
Diabetes	Yes	No	Pacemaker	Yes	No			
Emphysema	Yes	No	Psychiatric Care	Yes	No			
Do you wear contact lenses?	Yes	No						
Woman:								
Are you pregnant?	Yes	No	Due Date________________________			Are you nursing?	Yes	No
Taking birth control pills?	Yes	No						

Medications

List any medications you are currently taking and the correlating diagnosis:

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Allergies

Aspirin	Local Anesthetic
Codeine	Amoxicillin/Penicillin
Acrylic	Sulfa
Latex	Other____________
None	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian

X Date: