PATTERSON
FAMILY DENTAL

Dental Registration

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name First Name Middle Inital

Address _____ City _____ State _____ Zip _____

E-mail _____ Sex (Circle One) M F Age _____ Birthdate _____

Circle One: Married Widowed Single Minor

Patient Employer/School _____ Occupation _____

Employer School/Address _____ Employer School/Phone (_____) _____

Spouse's Name _____ Birthdate _____

Spouse's Employer _____

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____

Cell Phone (_____) _____ Spouse's Work (_____) _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY CONTACT (Specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

Please circle referral source:

Friend/Neighbor/Relative Name: _____ Internet - Google, Bing, etc. Drove By Facebook

Other _____

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Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions!

Are you under a physician's care now?	YES	NO	If yes, please list name
Have you ever been hospitalized or had a major operation?	YES	NO	If yes, please explain
Have you ever had a serious head or neck injury?	YES	NO	If yes, please explain
Are you taking any medications, pills or drugs?	YES	NO	If yes, please explain
Do you have any replacement joints such as knee, shoulder, or hip?	YES	NO	If yes, please explain
Are you on a special diet?	YES	NO	If yes, please explain
Do you use tobacco?	YES	NO	
Do you use controlled substances?	YES	NO	
Are you experiencing pain or discomfort?	YES	NO	
Are you in good health?	YES	NO	

Women:

Are you pregnant or trying to get pregnant?	YES	NO
Nursing?	YES	NO

Do you take any medications to treat Osteoporosis such as Fosmax, Aredia, Boniva, or Zometa?	YES	NO
Are you taking any blood thinners?	NO	YES
Have you ever been diagnosed with infective endocarditis?	NO	YES
Have you ever had heart valve replacement surgery?	NO	YES

Are you allergic to any of the following? (Please Circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

If other, please list _____

Do you have, or have had, any of the following (Please Circle) _____

AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problem
Bruise easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Emphysema
Epilepsy or Seizures
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pace Maker
Heart Trouble/Disease
Hemophilia
Hepatitis A, B or C
Herpes
High Blood Pressure
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Pain Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatments
Renal Dialysis
Rheumatic Fever
Rheumatism
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice