

PATIENT REGISTRATION

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Date _____

Name _____ Nickname _____

Address _____ City _____ State _____ Zip _____

Sex M F Date of Birth _____ Social Security # _____

Home Phone _____ Business Phone _____ Cell Phone _____

Marital Status S M W D Occupation _____

Employer _____ Address _____

School (if student) _____

Spouse or Guardian's Information: Name _____

Employer _____ Address _____

Business Phone _____ Social Security # _____

If covered by dental insurance - Name of insurance co. _____

Insurance coverage through: Self - Spouse - Parent(or guardian) Birthdate of insured _____

If secondary dental insurance exists - Name of insured _____

Secondary insurance co. _____ Birthdate of insured _____

In case of emergency: Name of a relative or close friend not living at your home _____ Phone _____

Who may we thank for referring you to our office? _____

PATIENT CONFIDENTIAL MEDICAL-DENTAL HISTORY

Height _____ Weight _____ Physician's Name _____

Yes No

Are you under any medical treatment now?..... _____

Have you been hospitalized or seriously ill in the last 2 years ?..... _____

Have you had any major operations? _____

If so, what? _____

Have you had any serious accidents involving head injuries? _____

Are you taking any medications or drugs at this time? _____

Please list: _____

Have any wounds healed slowly or with other complications? _____

Have you ever had radiation treatment for any condition? _____

Have you ever had any allergic reactions or adverse responses to any drugs or medications? _____

Please list: _____

For Women: Are you pregnant?..... _____

Do you take birth control pills? _____

(over)

Have you ever had any of the following conditions?

	yes	no		yes	no
Rheumatic fever	_____	_____	Tumors or Growths	_____	_____
Heart Trouble	_____	_____	Blood Disease	_____	_____
High Blood Pressure	_____	_____	Abnormal Bleeding	_____	_____
Respiratory Disease.....	_____	_____	Stroke	_____	_____
Diabetes.....	_____	_____	Liver Disease.....	_____	_____
Asthma	_____	_____	Hepatitis	_____	_____
Heart Murmur	_____	_____	Psychiatric Problems.....	_____	_____
Kidney Disease	_____	_____	Tuberculosis.....	_____	_____
Venereal Disease.....	_____	_____	AIDS or HIV Positive	_____	_____
Sinus Problems	_____	_____	Stomach Ulcers	_____	_____

Do you have any other medical problems that you feel we should be aware of?

If so, what? _____

Do you have, or have you had any of the following?

	yes	no		yes	no
Dentures (full or partial)	_____	_____	Bad Breath.....	_____	_____
Swelling of the Mouth	_____	_____	Gum Treatment	_____	_____
Complications from Extractions	_____	_____	Gag Easily	_____	_____
Grinding or Clenching of Teeth.....	_____	_____	Bleeding Gums.....	_____	_____
Lip or Mouth Blisters.....	_____	_____	Food Impaction	_____	_____
Unexplained Headaches.....	_____	_____	Unpleasant Taste.....	_____	_____
Popping or Clicking Jaws	_____	_____	Pain in Jaw Joint	_____	_____

Do you have teeth that are sensitive to hot, cold, sweets, etc.?

Do you have any dental complaints at this time?.....

Are you satisfied with the appearance of your teeth?

Have you had any serious problems with dental treatment?.....

Date of last dental exam _____ Full mouth x-ray series _____

Name and address of the dentist who _____

has your previous dental records _____

I certify that the information herein is correct to the best of my knowledge. I hereby grant Richard P. Gangwisch, D.D.S. and John D. Hulsey, D.M.D. permission to use the diagnostic and treatment photographs, models, and records of the above patient for the purpose of display for scientific articles, seminars, and presentations.

Signature _____ Date _____

Comments: