Welcome To Our Office!

Please print clearly and fill out this patient registration form completely. For any information that repeats that of the patient, you can print "same".

Today's Date: ____________________

Patient Information

Last Name: ________________ First Name: ________________ MI: ___ Nickname: ________________

Street Address: ________________________ City: ____________ State: _____ ZIP: __________

Home Phone: (____)__________ Work Phone: (____)__________ Cell Phone: (____)__________

Place a star after the phone number that is best for daytime contact. (If the patient is a minor, enter the name and the phone number of the parent we should contact here: ________________________________)

Patient's age: ___ Birthdate: ___/___/___ Sex: M / F Social Security No.: ________________

Marital Status: M D W S Occupation: ________________ Employer: ________________

Who referred you to our office or how did you hear about us? ________________________

Spouse info. Name: ________________ Work Phone: (____)__________ Cell Phone (____)__________

Home E-mail Address: ________________________

Responsible Party (If the patient is a child, the responsible party must be the parent or guardian with whom the child lives.)

Last Name: ________________ First Name: ________________ MI: ___ Nickname: ________________

Street Address: ________________________ City: ____________ State: _____ ZIP: __________

Home Phone: (____)__________ Work Phone: (____)__________ Cell Phone: (____)__________

Place a star after the phone number that is best for daytime contact.

Dental Insurance Information

Primary Insurance Co.: ________________ Phone: (____)__________ Group No.: ____________

Employee: ________________________ Birthdate: ____/____/____ S.S. No.: ____________

Employer: ________________________ Phone (____)__________ Dental Plan: ____________

Secondary Insurance Co.: ________________ Phone: (____)__________ Group No.: ____________

Employee: ________________________ Birthdate: ____/____/____ S.S. No.: ____________

Employer: ________________________ Phone: (____)__________ Dental Plan: ____________

Medical Information (Circle Y for yes or N for no where applicable.)

Are you currently undergoing treatment by a physician or psychiatrist? Explain: ________________ Y N

Physician's name and phone No.: ________________________

Do you have serious health problems? Explain: ________________________ Y N

Have you had a serious illness, operation or been hospitalized in the past 5 years? Explain: ________________ Y N

Are you taking prescription (including birth control pills) or over the counter medications?........ Y N

If so, please list here: ________________________

____

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Has a physician recommended that you take an antibiotic prior to any dental treatment? Explain: ________________ Y N

Have you had any joint replacements? Explain: ________________________ Y N

Do you have or have you had artificial heart valves, infective endocarditis, congenital heart disease (CHD), or damaged valves in a transplanted heart? Explain: ________________________ Y N

Are you currently taking or have you taken any bisphosphonate medications such as Actonel (risedronate), Aredia (pamidronate), Bonefos (clodronate), Boniva (ibandronate), Didronel (etidronate), Fosamax (alendronate), Ostac (clodronate), Skelid (tiludronate), Zometa (soledronic acid), and/or are you being treated for or have treatment planned for osteoporosis, Paget's Disease, multiple myeloma, bone diseases, or metastatic cancer? Explain: ________________________ Y N

Are you sensitive or allergic to any of the following?

Local anesthetics (such as lidocaine, mepivacaine, or bupivacaine)............ Y N

Pain medications............................... Y N

(Which: ________________)

Antibiotics.. Y N

(Which: ________________)

Barbituates, sedatives, sleeping pills.. Y N

Codeine or other narcotics.................. Y N

Metals..., ... Y N

Latex (rubber).. Y N

Plants (hay fever), pollens, molds............ Y N

Other (Explain: ________________) Y N

(CONTINUE ON BACKSIDE)

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

AIDS or HIV infection.......................Y N
Angina or chest pain.........................Y N
Arthritis...Y N
Asthma..Y N
Autoimmune disease.........................Y N
Bleeding problems, anemia, clotting...Y N
Blood pressure- high.........................Y N
Blood pressure- low...........................Y N
Blood thinners taken..........................Y N
Bone problems, osteoporosis..............Y N
Cancer, chemotherapy, radiation treatment...Y N
Chronic pain (Where: ____________) Y N
Diabetes...Y N

Epilepsy, fainting spells, seizures....... Y N
Glaucoma.. Y N
Headaches (frequent)......................... Y N
Heart attack (When: ____________) Y N
Heart disease or surgery..................... Y N
Heart murmur, defects, palpitations.... Y N
Heart valve problems, arteriosclerosis Y N
Hemophilia or blood disease .... Y N
Hepatitis, jaundice, liver disease.........Y N
Infection (recurrent)............................ Y N
Kidney problems................................ Y N
Leukemia..Y N
Lung problems, bronchitis, emphysema, difficulty breathing........ Y N

Mental health disorders..................... Y N
Neurological disorder......................... Y N
Night sweats....................................... Y N
Pacemaker.. Y N
Persistent swollen neck glands.......... Y N
Severe rapid weight loss..... .... Y N
Sexually transmitted disease.............. Y N
Sinus problems (frequent)...................Y N
Stomach, intestinal problems..............Y N
Stroke (When: ________________)....Y N
Systemic lupus erythematosus............Y N
Thyroid problems...............................Y N
Tuberculosis,blood with coughing.......Y N
Urination (frequent)........................... Y N

For women only- Are you pregnant? (If so, how far along:_______________).. Y N

Is there any disease, condition, or problem not listed above that you think we should know about?...................... Y N
Explain: ____

Dental Information

Last dentist seen: ______________ Date of last exam: ____________ Date of last cleaning: ____________
Have you had any serious problem with past dental treatment including anesthetics, medications, or clotting? Y N
Explain: ____

Have you had any of the following in the past?

Broken facial or jaw bones................. Y N
Facial nerve or mouth damage............ Y N
Gum deep cleaning (date: _________) Y N
Gum surgery (date: ______________) Y N
Jaw joint (TMJ) problems.................. Y N
Orthodontic treatment........................ Y N

Indicate which of the following conditions you currently have.

Bad breath concerns........................... Y N
Bleeding, sore gums........................... Y N
Grinding or clenching of teeth............ Y N
Jaw joint (TMJ) problems.................. Y N
Teeth are sensitive, painful or loose.... Y N
Tobacco use....................................... Y N

If you are not satisfied with your past dental treatment, tell us why? ____________________
What is your dental need or problem today? ______________________________
What, if anything, would you like changed about the appearance of your teeth or smile?
Explain: ____

I have received copies of the Office Information Sheet, the Dental Materials Fact Sheet, and the Health Information Notice of Privacy Practices Form. I have the right to review these forms thoroughly at home. I agree to the policies and information presented in them. I agree to have work done on myself and my family. I agree to notify the office of any changes in my medical history or dental insurance. I will be sure to have my treatment or financial questions answered before starting treatment. To the best of my knowledge, the information I have provided to the office is correct. I authorize my insurance payment, if any, to be sent directly to Alan L. Stott D.D.S. A photocopy of this is as if it were the original.

______________________________ ______________________ ____________
Patient's Signature (Parent or guardian if a minor) Date For office use

Staff use only- For yearly health history updates.

Date	Changes or comments	Initials	Date	Changes or comments	Initials