AV DENTAL

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE ________________________

1

LAST NAME	FIRST		MI
PREFERS TO BE CALLED BY			
ADDRESS			
CITY	STATE		ZIP
HOME PHONE NO.	WORK PHONE NO.		
CELL PHONE NO.	EMAIL		
BIRTHDATE	SOCIAL SECURITY NO.		
PLEASE SELECT ALL THAT APPLY	MALE FEMALE	SINGLE MARRIED SEPARATED DIVORCED WIDOWED	

2 DENTAL INSURANCE

PRIMARY INSURANCE CARRIER	GROUP NO.
EMPLOYER NAME	INSURED’S NAME
INSURED’S DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED’S I.D. NO.	INSURED’S SOCIAL SECURITY NO.
SECONDARY INSURANCE CARRIER	GROUP NO.
EMPLOYER NAME	INSURED’S NAME
INSURED’S DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED’S I.D. NO.	INSURED’S SOCIAL SECURITY NO.

3 GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE?	YES NO
NAME	RELATIONSHIP
WHO REFERRED YOU TO OUR OFFICE?	NAME
PERSON TO CONTACT FOR EMERGENCY	NAME
PHONE NO	RELATIONSHIP

4 PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER	
ADDRESS		
CITY	STATE	ZIP
OCCUPATION	EMPLOYER’S NAME	
EMPLOYER’S ADDRESS	EMPLOYER’S PHONE NO.	

AV DENTAL

PATIENT NAME	**DENTAL HISTORY**
DATE OF BIRTH	MEDICAL ALERT

Welcome! *So that we may provide you with the best possible care please complete both the medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? ____

____

Date of Last Dental Visit ____________ **Last Dental Cleaning** ____________ **Last Full Mouth X-rays** ____________

What was done at your last dental visit? ____

____

Previous Dentist's Name ____

Address ______________________________State__________Zip__________

Telephone ____

How frequently do you have dental examinations? ______________________________

How often do you brush your teeth? ____________________ How often do you floss? ____________________

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use (Waterpik, toothpick, etc.)? ____________________

Do you have any dental problems now? Yes No

If yes, please describe: ____

Are any of your teeth sensitive to:

Hot or cold?	Y	N
Sweets?	Y	N
Biting or Chewing?	Y	N
Have you noticed any mouth odors or bad tastes?	Y	N
Do you frequently get cold sores, blisters or any other oral lesions?	Y	N
Do your gums bleed or hurt?	Y	N
Have your parents experienced gum disease or tooth loss?	Y	N
Have you noticed any loose teeth or change in your bite?	Y	N
Does food tend to become caught in between your teeth?	Y	N

If yes, where?

____

Do you:

Clench or grind your teeth while awake or asleep?	Y	N
Bite your lips or cheeks regularly?	Y	N
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Y	N
Mouth breathe while awake or asleep?	Y	N
Have tired jaws, especially in the morning?	Y	N
Snore or have any other sleeping disorders?	Y	N
Smoke, chew tobacco or use other tobacco products?	Y	N

Have you ever had:

Orthodontic treatment?	Y	N
Oral Surgery?	Y	N
Periodontal treatment?	Y	N
Your teeth ground or the bite adjusted?	Y	N
A serious injury to the mouth or head?	Y	N

If so, please describe, including cause__________

____

Have you experienced:

Clicking or popping of the jaw?	Y	N
Pain? (joint, ear, side of face)	Y	N
Difficulty in opening or closing the mouth?	Y	N
Difficulty in chewing on either side of the mouth?	Y	N
Headaches, neck aches or shoulder aches?	Y	N
Sore muscles (neck, shoulders)?	Y	N
Are you satisfied with your teeth's appearance?	Y	N
Would you like to keep all of your teeth all of your life?	Y	N
Do you feel nervous about having dental treatment?	Y	N

If so, what is your biggest concern?____________

____

Have you ever had an upsetting dental experience?	Y	N

If yes, please describe ____________________

____

Have you ever been told to take a pre-medication prior to dental treatment?	Y	N
Is there anything else about having dental treatment that you would like us to know?	Y	N

If yes, please describe ____

____

AV DENTAL

PATIENT NAME	**MEDICAL HISTORY**
DATE OF BIRTH	MEDICAL ALERT

1. Physician's Name____ Phone ____________________________
   Have you had any medical care within the past two years? .... Y N
   Describe ____
2. Have you taken any medication or drugs during the past two years? .... Y N
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? .... Y N
   If yes, please list name and dosage ____
4. Have you ever taken prescription medications for weight loss (diet pills)? .... Y N
   If yes, did you take any of the following? (check if yes) Fen-Phen Pondimen Redux
   If yes to any of the above, did you have a medical exam for heart issues? .... Y N
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? .... Y N
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? .... Y N
7. Have you been a patient in the hospital during the past five years? .... Y N
8. Indicate which of the following you have had, or have at present. Check "Y" for yes or "N" for no to each item.

Heart (Surgery, Disease, Attack)….	Y	N	Ulcers……………………………………	Y	N	Hepatitis A B C	Y	N
Chest Pain……………………………..…….	Y	N	Diabetes…………………………………..	Y	N	Venereal Disease…………..……	Y	N
Congenital Heart Disease……..…….	Y	N	Thyroid Problems……………………	Y	N	A.I.D.S./ H.I.V. Positive……….	Y	N
Heart Murmur…………………….……….	Y	N	Glaucoma………………………………..	Y	N	Cold Sores/Fever Blisters…….	Y	N
High/Low Blood Pressure………………	Y	N	Contact lenses………………………..	Y	N	Blood Transfusion………………..	Y	N
Mitral Valve Prolapse…………………….	Y	N	Emphysema…………………………..	Y	N	Hemophilia………………………….	Y	N
Artificial Heart Valve/Pacemaker……	Y	N	Chronic Cough………………………..	Y	N	Sickle Cell Disease……………….	Y	N
Rheumatic Fever……………..………….	Y	N	Tuberculosis…………………………..	Y	N	Bruise Easily………………………..	Y	N
Arthritis/Rheumatism……….………….	Y	N	Asthma………………………………….	Y	N	Liver Disease/Jaundice…………	Y	N
Cortisone Medicine…………….…………	Y	N	Hay Fever/Allergy/Hives………..	Y	N	Neurological Disorders…………	Y	N
Swollen Ankles………………….…………	Y	N	Latex Sensitivity…………………….	Y	N	Epilepsy or Seizures…………...	Y	N
Stroke…………………………….…………..	Y	N	Sinus Trouble………………………..	Y	N	Fainting or Dizzy Spells………	Y	N
Diet (Special/Restricted)…….………..	Y	N	Radiation Therapy………………….	Y	N	Nervous/Anxious………………….	Y	N
Artificial Joints (hip, knee, etc.)…….	Y	N	Chemotherapy……………………….	Y	N	Under Psychiatric Care…………	Y	N
Kidney Trouble…………………………….	Y	N	Tumors………………………………….	Y	N			

9. Have you lost or gained more than 10 pounds in the past year? .... Y N
10. Do you have or have you had any disease, condition, or problem not listed? .... Y N
    If yes, please list: ____
11. **Women:** Are you pregnant or think you could be pregnant? Yes _________Months No **Nursing?** Yes No
12. Do you use birth control prescriptions? .... Y N

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature ____ Date _________________