WOODSIDE DENTAL CARE

Registration and Health History form

WE HAVE THE INTEREST AND DESIRE TO LISTEN, REALLY LISTEN, TO WHAT YOU ARE SAYING. PLEASE DON'T HESITATE TO ASK ABOUT ANYTHING YOU DON'T UNDERSTAND. YOU ARE DEALING WITH MEMBERS OF A TEAM WHOSE PRIMARY JOB IS TO SERVE YOU. WE PROMISE THAT YOU WILL NEVER LEAVE FEELING THAT NO ONE CARES.

In order to begin treatment the following information is necessary. Please complete fully and print legibly. All information will be held in strict confidence.

Name _____ (Last / First / Middle) Home Ph_____ Cell Ph_____ Spouse's Name_____

If patient is a minor, please give the name of a parent or legal guardian_____ (Last / First / Middle)

Residence Address_____ (Street) City_____ State_____ Zip Code_____

Mailing Address (if different than residence)_____ (Street) City_____ State_____ Zip Code_____

Date of Birth_____ SS#_____ Sex ☐M ☐F Email_____

Driver's License_____ Occupation_____ Employer_____

Employer Address_____ City_____ State_____ Zip Code_____

Emergency Contact_____ (Name) Relationship_____ Phone_____ (Relationship)

If you are completing this form for another person, what is your relationship to that person? _____

How may we contact you? Phone____ Mail____ Email____ Text Message___ All_____

INSURANCE

Policy Holder_____ Relationship to Patient_____ Insured DOB_____

SS# of Insured_____ Insured Employer_____ Insurance Company_____

Secondary Insurance ☐Yes ☐No - If Yes, Policy Holder_____ Relationship to Patient_____

Insured DOB_____ SS# of Insured_____ Insured Employer_____

DENTAL INFORMATION

For the following questions, please (X) whichever applies This information is vital to allow us to provide appropriate care for you.

Yes	No		Yes	No	
☐	☐	Do your gums occasionally bleed when you brush?	☐	☐	Have you ever had orthodontic (braces) treatment?
☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Do you have headaches, earaches or neck pain?
☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	Do you wear removable dental appliances?
☐	☐	Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain_____			

How would you describe your current dental problem?_____

Former Dentist_____ Reason for leaving_____

Date of your last dental exam_____ Date of last dental x-ray_____ What was done at that time?_____

Are you nervous about receiving dental care? ☐Yes ☐No Would you like to be sedated for treatment? ☐Yes ☐No

Are you participating in any sport? ☐Yes ☐No Do you wear a mouth guard? ☐Yes ☐No

How do you feel about the appearance of your teeth?_____

MEDICAL INFORMATION

These questions are for your benefit and assure that the treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition but they are all associated with proper oral care.

Yes	No	
☐	☐	Are you in good health?
☐	☐	Have there been any changes in your general health within the past year?
☐	☐	Are you under the care of a physician? If so, what is/are the condition(s) being treated?_____
		Date of last physical examination_____ Physican_____
☐	☐	Have you had any serious illness, operation, hospitalized in the past 5 years? If so, what was the illness or problem? _____

_____

Yes No

- ☐ ☐ Are you taking or have your recently taken any medicine(s) including no-prescription medicine? If so, what are you taking and what is the dosage?
  Prescribed _____
  Over the counter_____
  Natural or herbal preparations_____
- ☐ ☐ Have you taken any of the following prescription medications? Circle one ZOMETA AREDIA ACTONEL BONIVA FOSAMAX
- ☐ ☐ Do you drink alcoholic beverages? If Yes, how much alcohol did you drink in the last 24 hours?
- ☐ ☐ Are you alcohol and/or drug dependent? If so, have you received treatment? ☐Yes ☐No
- ☐ ☐ Do you use drugs or other substances for recreational purposes? If Yes, please list_____
  Frequency of use (daily, weekly, etc.)_____ Number of years of recreational drug use_____
- ☐ ☐ Do you use tobacco (smoking, snuff, chew)? If Yes, how much?_____
- ☐ ☐ Do you wear contact lenses?

ALLERGIES: ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO: (PLEASE FILL OUT EACH COLUMN)

Yes	No		Yes	No		Yes	No	
☐	☐	Local anesthetics	☐	☐	Sulfa drugs	☐	☐	Hay fever/seasonal
☐	☐	Aspirin	☐	☐	Codeine or other narcotics	☐	☐	Animals
☐	☐	Penicillin or other antibiotics	☐	☐	Latex	☐	☐	Food (specify)_____
☐	☐	Barbiturates, sedatives, or sleeping pills	☐	☐	Iodine	☐	☐	Other (specify)_____

To Yes responses, please type of reaction_____

Yes No

- ☐ ☐ Nursing?
- ☐ ☐ Are you pregnant? If Yes, how many months? _____
- ☐ ☐ Taking birth control pills?

Do you now or have you ever had any of the following? Please check YES or NO to ALL

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal bleeding	☐	☐	Disease, drug or radiation induced immunosurpression	☐	☐	Nights sweats
☐	☐	AIDS or HIV infections	☐	☐	Dry mouth	☐	☐	Osteoporosis
☐	☐	Angina. If YES date: _____	☐	☐	Eating disorder. If YES, specify: _____	☐	☐	Persistent swollen glands/neck
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Recurrent infections
☐	☐	Arteriosclerosis	☐	☐	Excessive urination	☐	☐	Respiratory problems
☐	☐	Arthritis	☐	☐	Fainting spells or seizures	☐	☐	Seizures
☐	☐	Asthma	☐	☐	G.I. reflux	☐	☐	Severe headaches / migraines
☐	☐	Blood transfusion If YES, date: _____	☐	☐	Glaucoma	☐	☐	Severe or rapid weight loss
☐	☐	Cancer/chemotherapy/radiation treatment If YES, date: _____	☐	☐	Heart attack. If YES, date: _____	☐	☐	Sexually transmitted disease
☐	☐	Cardiovascular disease	☐	☐	Hemophilia	☐	☐	Sinus trouble
☐	☐	Artificial heart valves	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	Sores or ulcers in the mouth
☐	☐	Pacemaker	☐	☐	High blood pressure	☐	☐	Stroke. If YES, date: _____
☐	☐	Damaged heart valves	☐	☐	Implants	☐	☐	Systemic lupus erythematosus
☐	☐	Heart murmur	☐	☐	Joint replacement, If YES, date: _____ Where: _____	☐	☐	Thyroid problems
☐	☐	Inborn heart defects				☐	☐	TMJ
☐	☐	Mitral valve prolapse	☐	☐	Kidney problems	☐	☐	Tuberculosis
☐	☐	Rheumatic heart disease	☐	☐	Low blood pressure	☐	☐	Ulcers
☐	☐	Chronic pain	☐	☐	Mental health disorders. If YES, specify: _____	☐	☐	Do you have any disease, condition or problem not listed above that you think I should know about? Please explain: _____
☐	☐	Chest pain upon exertion						
☐	☐	Diabetes, If YES specify below: _____	☐	☐	Neurological disorders. If YES, specify: _____			

- ☐ ☐ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose? _____

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

I certify that I have read and understand the above. To the best of my knowledge, all of the preceding answers are true and correct I understand that it is my responsibility to advise this office of any changes in th information contained on this form.. I acknowledge that my questions if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsibility for any action they take to do not take because of errors or omissions that I may have made in the completion of this form. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable before or at the time of service unless other arrangements have been made. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to the use the appropriate medication and therapy indicate for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. I hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnoses of any dental needs I hereby authorize my dentist to release any and all medical or dental information to my insurance carrier for purpose of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

_____ _____
Signature of Patient / Legal Guardian Date

_____ _____ _____ _____
Assistant Signature Date Dentist Signature Date