WILLIAM F. DODSON, DDS, FACP
Exceptional family dentistry that's all about you.

24551 Silver Cloud Court, Suite 202
Monterey, CA 93940
P/ (831) 649-1982
www.dodsondds.com

Patient Registration

GENERAL INFORMATION _____

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms Date _____

_____ Birthdate _____
Last *First* *Middle*

Residence Address _____ Telephone (____) _____
(Number, Street, City, St, Zip)

If less than one year, your previous address _____
(Number, Street, City, St, Zip)

Cell phone (____) _____ e-Mail _____

Marital Status ____ Social Security No. _____ Drivers license No. _____

Occupation _____ Employer _____

Residence Address _____ Telephone (____) _____
(Number, Street, City, St, Zip)

Name of Spouse _____ Spouse's Social Security No. _____

Occupation _____ Employer _____

Address of Employer _____ Telephone (____) _____
(Number, Street, City, St, Zip)

If patient is a minor, who is legally responsible? _____

Address _____ Telephone (____) _____
(Number, Street, City, St, Zip)

By whom were you referred?_____ When?_____

INSURANCE INFORMATION _____

If you have· any type of dental insurance, please complete the following. If not, skip.

Name of Insurance Carrier _____

Name of Group Dental Plan _____ Group No. _____

Employee's Name _____ Employee's Social Security No. _____

Patient _____ Relationship to employee _____ Employee's Birthdate _____

Employer _____

Address of Employer _____ Telephone (____) _____
(Number, Street, City, St, Zip)

Union Local Name _____ Union Local No. _____

Address of Union _____ Telephone (____) _____
(Number, Street, City, St, Zip)

Has the patient had previous dental care under this plan? ❑ Yes ❑ No *If yes, when?*_____

Is the patient covered by another plan? ❑ Yes ❑ No *If yes, Name of the Plan*? _____

Employer _____

Address of Employer _____ Telephone (____) _____
(Number, Street, City, St, Zip)

Please be sure* to *obtain* a *copy of* the *Office Policy regarding Insurance Programs

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MEDICAL HISTORY

Family Physician _____ Specialty _____

Address _____
Number Street City State Zip Code Area Code -Telephone

Additional Physician _____ Specialty _____

Address _____
Number Street City State Zip Code Area Code -Telephone

Height _____ Weight _____ Age _____ Date of last complete medical examination? _____

Please check Yes or No. *If YES, please fill in details.*

❑ Yes ❑ No Do you have a current medical problem? What? _____
❑ Yes ❑ No Do you have heart trouble? What kind? _____
❑ Yes ❑ No Have you' had rheumatic fever? When? _____
❑ Yes ❑ No Do you have high or low blood pressure? Is it controlled? _____
❑ Yes ❑ No Have you had pains in the chest or shortness of breath? _____
❑ Yes ❑ No Do your ankles ever swell? _____
❑ Yes ❑ No Has your physician ever told you that you are anemic? _____
❑ Yes ❑ No Have you ever had a stroke? When? _____
❑ Yes ❑ No Have you ever had diabetes? How is it controlled? _____
❑ Yes ❑ No Are you subject to fainting or dizziness? When? _____
❑ Yes ❑ No Do you have headaches? How often? _____
❑ Yes ❑ No Do you have problems with insomnia? How often? _____
❑ Yes ❑ No Do you have any nervous disorder? How is it controlled? _____
❑ Yes ❑ No Do you take tranquilizers or sedatives? How often? _____
❑ Yes ❑ No Do you take aspirin? How often? _____
❑ Yes ❑ No Are you allergic to any medication? What? _____
❑ Yes ❑ No Have you been advised not to take any medication? What? _____
❑ Yes ❑ No Do you have asthma or hay fever? How is it controlled? _____
❑ Yes ❑ No Have you ever had tuberculosis? When? _____
❑ Yes ❑ No Have you ever had infectious hepatitis? When? _____
❑ Yes ❑ No Do you have arthritis? How is it controlled? _____
❑ Yes ❑ No Have you ever had a tumor or cancer? How was it treated? _____
❑ Yes ❑ No Have you had any major operations? What kind? _____
❑ Yes ❑ No Have you ever been involved in a serious accident? _____
❑ Yes ❑ No Are you taking any medication? *Please list:*
Taking _____ For _____ Taking _____ For _____
Taking _____ For _____ Taking _____ For _____
Taking _____ For _____ Taking _____ For _____
❑ Yes ❑ No Have you gained or lost weight within the last year? How much? _____
❑ Yes ❑ No Do you become fatigued easily? At what time of day? _____
❑ Yes ❑ No Do you routinely eat breakfast? What? _
❑ Yes ❑ No Do you take more than one alcoholic drink per day? How many? _____
❑ Yes ❑ No Do you use tobacco? How much? _____
❑ Yes ❑ No Is your diet medically supervised? For what purpose? _____

FOR WOMEN

❑ Yes ❑ No Are you pregnant? Expected delivery date _____
❑ Yes ❑ No Do you have any history of previous miscarriages? _____
❑ Yes ❑ No Have you reached menopause? If so, are you taking supportive medication? _____

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DENTAL HISTORY

Previous Dentist _____ Period of Treatment _____ Specialty _____

Address _____ Telephone (____) _____
(Number, Street, City, St, Zip)

Other Dentist _____ Period of Treatment _____ Specialty _____

Address _____ Telephone (____) _____
(Number, Street, City, St, Zip)

Last dental visit? _____ Last full-mouth x-ray? _____ Last complete dental exam? ___

What is your immediate dental concern? _____

Please check Yes or No. *If YES, please fill in details.*

❑ Yes ❑ No Are you presently in any dental pain? _____

❑ Yes ❑ No Have you ever experienced any unfavorable reaction to dentistry? _____
What? _____

❑ Yes ❑ No Have you lost any teeth? From what cause? _____

❑ Yes ❑ No Have you ever had orthodontic treatment? When? _____

❑ Yes ❑ No Do you have any growths or swellings in your mouth? _____

❑ Yes ❑ No Do you have any difficulty in swallowing? _____

❑ Yes ❑ No Do your gums bleed when brushing your mouth? _____

❑ Yes ❑ No Do you avoid brushing any part 01 your mouth? Why? _____

❑ Yes ❑ No Have you ever been told you have pyorrhea? When? _____

❑ Yes ❑ No Is any part of your mouth sensitive to temperature, pressure, food or drink? What? _____

❑ Yes ❑ No Do you have a burning sensation in your mouth? _____

❑ Yes ❑ No Have you ever had a bad reaction to a dental anesthetic? When? _____

❑ Yes ❑ No Does food catch between your teeth? _____

❑ Yes ❑ No Do you have pain or soreness around your eyes, ears or other parts of your face? _____
When? _____

❑ Yes ❑ No Are you aware of stiff neck muscles? How often? _____

❑ Yes ❑ No Do you ever awaken with awareness of your teeth or jaws? How often? _____

❑ Yes ❑ No Are you aware of clenching your teeth during daytime hours? How often? _____

❑ Yes ❑ No Have you ever been told you grind your teeth during sleep? How often? _____

❑ Yes ❑ No Are you aware of your jaw clicking or popping while eating or yawning? How often? _____

❑ Yes ❑ No Do you have difficulty in opening your mouth widely? _____

❑ Yes ❑ No Do you have -tension- headaches/ How often? _____

❑ Yes ❑ No Do you have an unpleasant taste or odor in your mouth? _____

❑ Yes ❑ No Are you dissatisfied with your teeth and their appearance? _____

❑ Yes ❑ No Do you feel you will eventually wear full artificial dentures? _____

❑ Yes ❑ No Do any members of your family including your parents wear dentures? _____

❑ Yes ❑ No Do you think your dental disease is active? _____

❑ Yes ❑ No Do you want to learn to control your dental disease and retain your teeth? _____

❑ Yes ❑ No Are you deeply concerned about the finances required to return your mouth to excellent dental health? _____

❑ Yes ❑ No Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? _____

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SUPPLEMENTAL DENTURE HISTORY _____

If you wear a partial or complete artificial denture, please complete the following:

- For what reasons were your teeth lost? _____
- When did you receive your first partial or complete denture? _____
- Approximate date of extractions: _____
- Was your first complete denture placed the same day the teeth were extracted? _____
- How many complete or partial dentures have you had? Upper? _____ Lower? _____
- How long have you worn your present denture? _____
- Has it been relined? _____
- Your last denture was constructed by: _____
- What is your present denture problem? _____
- Are you satisfied with the appearance of your dentures? _____
- Are you satisfied with the comfort of your dentures? _____
- Are you satisfied with the chewing ability? _____
- Do you wear your dentures 24 hours a day? _____ *If not, why not?* _____
- Do you bite your tongue or cheek with your dentures? _____
- Do your dentures click during speech? _____
- Do your dentures influence your speech?_____ *How?* _____
- What do you expect of your new denture? _____

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his/her Staff, and assume financial responsibility.

Signature _____ Date _____

Please be sure to obtain a copy of the Office Policy regarding financial arrangements.

FORM CER 210
Dental Printing Service, P.O. Box 730, Paradise, CA 95967-0730 • (916) 877.9693 • FAX: (916) 877.9662