

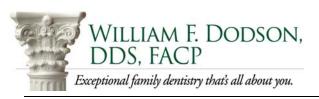
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## **Patient Registration**

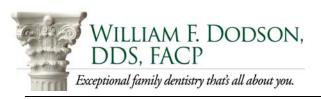
□ Dr. □ Mr. □ Mrs	s. 🗖 Miss	☐ Ms			Date
 Last		First		Middle	_ Birthdate
Residence Address					_ Telephone ()
1100100110071001000			et, City, St, Zip)		
If less than one year	r, your prev	vious addres	ss		
				(Number, Street,	
, , ,					
Marital Status	Social S	ecurity No.		[	Orivers license No.
Occupation		En	nployer		
Residence Address					_ Telephone ()
		•	et, City, St, Zip)		
-				-	cial Security No.
-					
Address of Employe					_ Telephone ()
If madant is a main or		•	et, City, St, Zip)		
If patient is a minor,					
Address					_ Telephone ()
(Number, Street, City, St, Zip)  By whom were you referred?				When?	
If you have any type					
					•
					Pagial Cagurity No.
					Social Security No
				-	_ Employee's Birthdate
Employer					
Address of Employe			et, City, St, Zip)		_ Telephone ()
					lo.
Union Local Name					
Union Local Name					_ Telephone ()
Union Local Name Address of Union		(Number, Stre	et, City, St, Zip)		
Address of Union		(Number, Stre	,	? □ Yes □ No	o If yes, when?
Address of Union Has the patient had	previous d	(Number, Stre ental care u	inder this plan		•
Address of Union Has the patient had Is the patient covere	previous d	(Number, Stre ental care u er plan? □	inder this plan Yes □ No <i>If</i>	yes, Name of t	o If yes, when?he Plan?
Address of Union Has the patient had Is the patient covere	previous d	(Number, Stre ental care u er plan? □	ınder this plan I Yes □ No <i>If</i>	yes, Name of t	he Plan?

File: NewPatientPacket

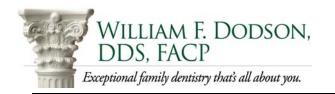
Rev. May 7, 2013



MEDIC	CAL HI	STORY				
Family Physician Specialty						
Addres						
		mber Street City State Zip Code Area Code -Telephone				
	•	sician Specialty				
Addres		mber Street City State Zip Code Area Code -Telephone				
Height		Weight Age Date of last complete medical examination?				
_		Yes or No. If YES, please fill in details.				
		Do you have a current medical problem? What?				
		Do you have heart trouble? What kind?				
		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		Do your ankles ever swell?				
☐ Yes		Has your physician ever told you that you are anemic?				
	□ No	Have you ever had a stroke? When?				
		Have you ever had diabetes? How is it controlled?				
☐ Yes☐ Yes☐	□ No	Are you subject to fainting or dizziness? When?				
☐ Yes		Do you have headaches? How often?				
☐ Yes		Do you have any nervous disorder? How is it controlled?				
☐ Yes		Do you take tranquilizers or sedatives? How often?				
☐ Yes		Do you take aspirin? How often?				
☐ Yes		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?				
	□ No	Have you ever had a tumor or cancer? How was it treated?				
☐ Yes		Have you had any major operations? What kind?				
☐ Yes		Have you ever been involved in a serious accident?				
☐ Yes	□ INO	Are you taking any medication? <i>Please list:</i> Taking For For				
		Taking         For         Taking         For           Taking         For         For				
		Taking For Taking For				
□ Yes	□ No	Have you gained or lost weight within the last year? How much?				
		Do you become fatigued easily? At what time of day?				
		Do you routinely eat breakfast? What? _				
		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 V	NOME	V				
		Are you pregnant? Expected delivery date				
		Do you have any history of previous miscarriages?				
☐ Yes	☐ No	Have you reached menopause? If so, are you taking supportive medication?				



DENT	AL HIS	STORY				
Previous Dentist		ist Period of Treatment Specialty				
Address		Telephone ()				
		(Number, Street, City, St, Zip)				
Other D	Dentist	Period of Treatment Specialty				
Addres	s	Telephone ()				
		(Number, Street, City, St, Zip)				
Last de	ntal vis	it? Last full-mouth x-ray? Last complete dental exam?				
What is	your ir	nmediate 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?				
☐ 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					
☐ 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?				



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.				
Sigi	nature 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

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