Patient Registration

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive.

Patient Name _____ MI _____ Preferred Name _____ Birth Date _____

Address _____ City/State _____ Zip _____

Home Phone _____ Work Phone _____ May we contact you there? Y N

Cell phone _____ Would you like text reminders? Y N

S.S.N. _____ _____ Married _____ Divorced_____ Single_____Child_____

Email _____ Would you like email reminders? Y N

Physician _____ City/State_____ Phone Number _____

Emergency contact _____ Phone Number _____

Whom may we thank for this referral? _____

Person Financially Responsible for the Account

Name _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ City/State /Zip_____

Employer _____ Occupation _____

If minor, Parent Daytime Phone Number _____

Dental Insurance YES NO

Primary Insurance

Employer _____
Employee _____
Date of Birth _____
SS#/Member ID_____
Insurance Company _____
_____
Group Number _____

Secondary Insurance

Employer _____
Employee _____
Date of Birth _____
SS#/Member ID_____
Insurance Company _____
_____
Group Number _____

Medical History

Last Physical Date _____ Results _____

Are you taking any prescription or over the counter medication now? YES NO

If yes, please list name and dosage _____

Have you been under the care of a physician for any condition or surgery in the past five years? YES NO

If yes, for what? _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment

YES NO If yes what antibiotic and dose? _____

Are you allergic to any of the following?

_____ Aspirin _____ Penicillin _____ Codeine _____ Acrylic _____Metal _____Latex _____Local Anesthetics

Other If yes, please list_____

Please circle the following conditions you have or have had:

CARDIOVASCULAR SYSTEM

-Angina (chest pains)
-Arteriosclerosis
-Congenital heart defects
-Coronary artery disease
-Damaged heart valves
-Heart murmur
-Heart attack (Date_____)
-COPD
-Mitral valve prolapse
-Heart valve replacement
-Pacemaker
-High cholesterol
-High/Low blood pressure
-Stroke (Date_____)
-Rheumatic fever
-Tuberculosis
-Emphysema
-Asthma
-Sleep apnea

CIRCULATORY

-Jaundice
-Hepatitis A, B, or C
-Blood transfusion
-Hemophilia
-Sickle cell anemia

IMMUNE SYSTEM

-Immunosuppression
-Diabetes (Type I or II)
-Lupus
-Seasonal allergies
-Chronic sinus congestion
-HIV positive/AIDS
-Sjogren's Syndrome
-Cancer (Date_____)
(Type_____)
(Radiation? Yes / No
Site_____)
(Chemotherapy? Yes / No)

MUSCULOSKELETAL

-Artificial joint(s) Joint_____
(Date_____)
-Osteoarthritis
-Rheumatoid arthritis
-Osteoporosis

DIGESTIVE/ENDOCRINE

-Special/restricted diet
-History of anorexia / bulimia
-Ulcers
-Liver disease
-Kidney disease
-GERD/acid reflux
-Gastrointestinal disease
-Gastric bypass
-Hypo/hyperthyroidism

NERVOUS/PSYCHOLOGICAL

-Glaucoma
-Neurological disorders
-Fainting
-Dizziness/vertigo
-Epilepsy or seizures
-Anxiety disorder
-Mental health disorder
(Condition_____)
-Autism
-ADHD

DRUG/MEDICATION USE

-Tobacco use (past/present)
(Type_____)
(How much_____)
(How long_____)
-Use of recreational drugs
-Taken bisphosphonates
-Taken Fen-Phen, Redux, or Pondimin

-Sexually transmitted disease
(Specify_____)

WOMEN

-Currently pregnant
(Due date_____)
-Thinking of becoming pregnant
-Currently nursing
-Currently taking birth control pills

DENTAL HISTORY

Date of last dental visit _____Last dental cleaning _____Last Full mouth x-rays _____
Previous Dentists Name _____Address _____
City/State _____Zip _____ Telephone _____
How often do you brush your teeth? _____Floss? _____
What other dental aids do you use? (Sonicare, Waterpik, Toothpick, etc.) _____
Do you have any dental problems now? Yes No If yes, please describe: _____

PAST DENTAL TREATMENT

-Had orthodontic treatment (braces)
-Had oral surgery (Type_____)
-Been diagnosed with or treated for periodontal (gum) disease
-Diagnosed or treated for oral cancer
-Wear any removable dental appliances (mouthguard, partials, dentures, retainers)

DENTAL CONDITIONS

-Teeth sensitive to hot / cold / biting / sweets
-Jaw clicking or popping (with / without pain)
-Tired jaw
-Chronic head / neck / ear aches
-Muscle pain in face or neck
-Feel you have chronic bad breath
-Gums bleeding or hurting
-Food always catching in teeth
-Mouth breathe while asleep or awake
-Feel like your mouth is always dry
-Have recurrent canker sores (inside mouth)
-Have recurrent cold sores (outside mouth)
Bite/chew your lips or cheeks regularly

CONSENT FOR TREATMENT

I have reviewed this questionnaire and answered its questions accurately and to the best of my knowledge. I understand that the answers I have provided will be used by Dr. Buchholtz to determine appropriate dental treatment. I agree to notify Dr. Buchholtz if any health changes occur. I authorize Dr. Buchholtz and the dental staff to perform the necessary dental services. I authorize the dental staff to release all information necessary to secure payment of benefits. I authorize my insurance company to pay Dr. Buchholtz directly. I authorize the use of this signature on all insurance submissions. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered. I understand that I am financially responsible for any charges not covered by my dental insurance.

Patient _____ Date_____

Parent or responsible party _____

Relationship to patient _____