Westhampton Dental

DR. ERIC CHRISTENSEN DDS

PATIENT REGISTRATION FORM

REVIEWED BY: _____

EMAIL:		TODAY'S DATE:	
PREFERRED NAME: ◯MISS ◯MR. ◯MRS. ◯MS. ◯DR.		REFERRED BY:	
NAME: Last First Middle		HOME PHONE:	CELL PHONE:
ADDRESS:	CITY:	STATE:	ZIP:
SSN:	**DATE OF BIRTH:**		SEX: M ◯ F ◯
EMPLOYER:		BUSINESS PHONE	
EMERGENCY CONTACT: RELATIONSHIP:		HOME PHONE	CELL PHONE
COLLEGE STATUS: ◯FULL TIME ◯PART TIME		SCHOOL NAME:	
EMPLOYMENT STATUS: ◯FULL TIME ◯PART TIME ◯RETIRED		ADDRESS:	
MARITAL STATUS: ◯MARRIED ◯SINGLE ◯DIVORCED ◯SEPARATED ◯WIDOWED		ADDRESS 2:	
PREF. PHARMACY	PHONE:	CITY /STATE/ ZIP:	

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: ◯SELF ◯SPOUSE ◯CHILD ◯OTHER

INSURED SSN: _____ INSURED BIRTH DATE: _____

EMPLOYER: _____ INS. COMPANY: _____

ADDRESS: _____ ADDRESS: _____

ADDRESS 2: _____ ADDRESS 2: _____

CITY/STATE/ZIP: _____ CITY/STATE/ZIP: _____

ID #: _____ GR #: _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: ◯ SELF ◯ SPOUSE ◯ CHILD ◯ OTHER

INSURED SSN: _____ INSURED BIRTH DATE: _____

EMPLOYER: _____ INS. COMPANY: _____

ADDRESS: _____ ADDRESS: _____

ADDRESS 2: _____ ADDRESS 2: _____

CITY/STATE/ZIP: _____ CITY/STATE/ZIP: _____

ID #: _____ GR #: _____

DENTAL INFORMATION FOR THE FOLLOWING QUESTIONS, MARK (X) YOUR RESPONSE TO THE FOLLOWING QUESTIONS. (Y-YES, N-NO, DK-DON'T KNOW)

	Y	N	DK		Y	N	DK
DO YOUR GUMS BLEED WHEN YOU BRUSH OR FLOSS?	◯	◯	◯	DO YOU HAVE ANY EARACHES OR NECK PAINS?	◯	◯	◯
ARE YOUR TEETH SENSITIVE TO COLD, HOT, SWEETS OR PRESSURE?	◯	◯	◯	DO YOU HAVE ANY CLICKING, POPPING, OR DISCOMFORT IN THE JAW?	◯	◯	◯
IS YOUR MOUTH DRY?	◯	◯	◯	DO YOU BRUX OR GRIND YOUR TEETH?	◯	◯	◯
HAVE YOU HAD ANY PERIODONTAL (GUM) TREATMENTS?	◯	◯	◯	DO YOU HAVE SORES OR ULCERS IN YOUR MOUTH?	◯	◯	◯
HAVE YOU EVER HAD ANY ORTHODONTIC (BRACES) TREATMENTS?	◯	◯	◯	DO YOU WEAR DENTURES OR PARTIALS?	◯	◯	◯
HAVE YOU EVER HAD ANY PROBLEMS ASSOCIATED WITH PREVIOUS DENTAL TREATMENTS?	◯	◯	◯	DO YOU PARTICIPATE IN ACTIVE RECREATIONAL ACTIVITES?	◯	◯	◯
				HAVE YOU EVER HAD A SERIOUS INJURY TO YOUR HEAD OR MOUTH?	◯	◯	◯
IS YOUR HOME WATER SUPPLY FLOURIDATED?	◯	◯	◯	DATE OF YOUR LAST DENTAL EXAM: WHAT WAS DONE AT THIS TIME?			
DO YOU DRINK BOTTLED OR FILTERED WATER?IF YES, HOW OFTEN? ◯DAILY ◯WEEKLY ◯OCCASIONALLY	◯	◯	◯				
ARE YOU CURRENTLY EXERIENCING DENTAL PAIN OR DISCOMFORT?	◯	◯	◯	DATE OF LAST DENTAL X-RAYS:			
WHAT IS THE REASON FOR YOUR DENTAL VISIT TODAY?							
HOW DO YOU FEEL ABOUT YOUR SMILE?							

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MEDICAL INFORMATION

PLEASE MARK (X) YOUR RESPONSES TO INDICATE IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS.

	Y	N	DK
ARE YOU UNDER THE CARE OF A PHYSICIAN?	○	○	○
PHYSICIAN NAME:			
PHONE NUMBER:			
ADDRESS/CITY/STATE//ZIP:			
ARE YOU IN GOOD HEALTH?	○	○	○
HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?	○	○	○
IF YES, WHAT CONDITION WAS TREATED?			
DATE OF LAST PHYSICAL EXAM:			
DO YOU WEAR CONTACT LENSES?	○	○	○
ARE YOU TAKING, OR HAVE YOU TAKEN, ANY DIET DRUGS SUCH AS PONDIMIN (FENFLURAMINE), REDUX (DEXPHENFLUREMINE) OR FEN-PHEN (FENFLURAMINE-PHENTEMINE COMBINATION)?	○	○	○
ARE YOU TAKING OR SCHEDULED TO BEGIN TAKING EITHER OF THE MEDICATIONS ALENDRONTATE (FOSAMAX®) OR RISENDRONATE (ACTONEL®) FOR OSTEOPOROSIS OR PAGET'S DISEASE?	○	○	○
SINCE 2001, WERE YOU TREATED OR ARE YOU PRESENTLY SCHEDULED TO BEGIN TREATMENT WITH THE INTRAVENOUS BISPHOSPHONATES (AREDIA® OR ZOMETA®) FOR BONE PAIN, HYPERCALCEMIA OR SKELETAL COMPLICATIONS RESULTING FROM PAGET'S DISEASE, MULTIPLE MYELOMA OR METASTIC CANCER?	○	○	○
DATE TREATMENT BEGAN:			

	Y	N	DK
HAVE YOU HAD A SERIOUS ILLNESS, OPERATION OR BEEN HOSPITALIZED IN THE PAST 5 YEARS?	○	○	○
IF YES, WHAT WAS THE ILLNESS OR PROBLEM?			
ARE YOU TAKING OR HAVE YOU RECENTLY TAKEN ANY PRESCRIPTION OR OVER-THE-COUNTER MEDICINE(S)?	○	○	○
IF SO, PLEASE LIST ALL, INCLUDING VITAMINS, NATURAL OR HERBAL PREPARATIONS, AND/OR DIET SUPPLEMENTS:			
DO YOU USE CONTROLLED SUBSTANCES (DRUGS)?	○	○	○
DO YOU USE TOBACCO (SMOKING, SNUFF, CHEW, BIDIS)?	○	○	○
IF SO, HOW INTERESTED ARE YOU IN STOPPING? CIRCLE ONE: VERY / SOMEWHAT / NOT INTERESTED			
DO YOU DRINK ALCOHOLIC BEVERAGES?	○	○	○
IF YES, HOW MUCH ALCOHOL DID YOU DRINK IN THE LAST 24HRS?			
IF YES, HOW MUCH DO YOU TYPICALLY DRINK IN A WEEK?			
WOMEN ONLY, ARE YOU:			
PREGNANT?	○	○	○
NUMBER OF WEEKS:			
TAKING BIRTH CONTROL PILLS OR HORMONE REPLACEMENT?	○	○	○
NURSING?	○	○	○

JOINT REPLACEMENT. HAVE YOU EVER HAD AN ORTHOPEDIC TOTAL JOINT REPLACEMENT (HIP, KNEE, ELBOW, FINGER)? ○ ○ ○

DATE: _____ IF YES, HAVE YOU HAD ANY COMPLICATIONS? _____

ALLERGIES. ARE YOU ALLERGIC TO OR HAVE HAD A REACTION TO: (TO ALL YES RESPONSES, SPECIFY TYPE OF REACTION.)

	Y	N	DK		Y	N	DK
LOCAL ANESTHETICS	○	○	○	METALS	○	○	○
PENICILLIN OR ANTIBIOTICS	○	○	○	LATEX (RUBBER)	○	○	○
BARBITUATES, SEDATIVES, OR SLEEPING PILLS	○	○	○	HAY FEVER/SEASONAL	○	○	○
SULFA DRUGS	○	○	○	ANIMALS	○	○	○
COCAINE OR OTHER NARCOTICS	○	○	○	FOOD	○	○	○
				OTHER	○	○	○

	Y	N	DK		Y	N	DK		Y	N	DK		Y	N	DK
HEART MURMUR	○	○	○	ANEMIA	○	○	○	CHEST PAIN UPON EXERTION	○	○	○	NEUROLOGICAL DISORDERS	○	○	○
MITRAL VALVE PROLAPSE	○	○	○	BLOOD TRANSFUSION	○	○	○	CHRONIC PAIN	○	○	○	IF YES, SPECIFY			
ARTIFICIAL HEART VALVES	○	○	○	IF YES, DATE				DIABETES TYPE I OR II	○	○	○	SLEEP DISORDER	○	○	○
RHEUMATIC FEVER	○	○	○	HEMOPHILIA	○	○	○	EATING DISORDER	○	○	○	MEANTAL HEALTH DISORDER	○	○	○
CARDIOVASCULAR DISEASE	○	○	○	AIDS OR HIV INFECTION	○	○	○	MALNUTRITION	○	○	○	IF YES, SPECIFY			
ANGINA	○	○	○	ARTHRITIS	○	○	○	GASTROINTESTINAL DISEASE	○	○	○	RECURRENT INFECTIONS	○	○	○
ARTERIOSCLEROSIS	○	○	○	AUTOIMMUNE DISEASE	○	○	○	GE REFLUX / PERSISTENT				TYPE OF INFECTION			
CONGESTIVE HEART FAILURE	○	○	○	RHEUMATOID ARTHRITIS	○	○	○	HEARTBURN	○	○	○	KIDNEY PROBLEMS	○	○	○
CORONARY ARTERY DISEASE	○	○	○	SYSTEMIC LUPUS				ULCERS	○	○	○	NIGHT SWEATS	○	○	○
DAMAGED HEART VALVES	○	○	○	ERYTHEMATOSUS	○	○	○	THYROID PROBLEMS	○	○	○	OSTEOPOROSIS	○	○	○
HEART ATTACK	○	○	○	ASTHMA	○	○	○	STROKE	○	○	○	PERSISTENT SWOLLEN			
LOW BLOOD PRESSURE	○	○	○	BRONCHITIS	○	○	○	GLAUCOMA	○	○	○	GLANDS IN NECK	○	○	○
HIGH BLOOD PRESSURE	○	○	○	EMPHYSEMA	○	○	○	HEPITITUS, JAUNDICE, OR				SEVERE HEADACHES /			
CONGENITAL HEART DEFECTS	○	○	○	SINUS TROUBLE	○	○	○	LIVER DISEASE	○	○	○	MIGRAINES	○	○	○
PACEMAKER	○	○	○	TUBERCULOSIS	○	○	○	EPILEPSY	○	○	○	SEVERE/RAPID WEIGHT LOSS	○	○	○
RHEUMATIC HEART DISEASE	○	○	○	CANCER/CHEMOTHERAPY/				FAINTING SPELLS OR				SEXUALLY TRANSMITTED DISEASE	○	○	○
ABNORMAL BLEEDING	○	○	○	RADIATION TREATMENT	○	○	○	SEIZURES	○	○	○	EXCESSIVE URINATION	○	○	○

HAS A PHYSICIAN OR PREVIOUS DENTIST RECOMMENDED THAT YOU TAKE ANTIBIOTICS PRIOR TO YOUR DENTAL TREATMENT?	○	○	○
NAME OF PHYSICIAN OR DENTIST MAKING RECOMMENDATION: _____ PHONE _____			
DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT?	○	○	○
PLEASE EXPLAIN:			

NOTE: BOTH DOCTOR AND PATIENT ARE ENCOURAGED TO DISCUSS ANY AND ALL RELEVANT PATIENT ISSUES PRIOR TO TREATMENT.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE AND THAT THE INFORMATION GIVEN ON THIS FORM IS ACCURATE. I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND THAT MY DENTIST AND HIS/HER STAFF WILL RELY ON THIS INFORMATION FOR TREATING ME I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DENTIST, OR ANY OTHER MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ACTION THEY TAKE OR DO NOT TAKE BECUASE OF ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGNATURE OF PATIENT/LEGAL GUARDIAN: _____ DATE: _____

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