PRECISION
DENTISTRY

New Patient Registration

Name:
Address:
City: Prov: Postal Code:
Phone Number:
Email:
Birth date:
Patient Signature:

Dental History

Please circle or mark the correct response and provide additional information where indicated.

Are you having pain at this time?	Y	N
Have you ever had complications related to dental treatment?	Y	N
Do you have any dental implants?	Y	N
Are you aware of any loose teeth?	Y	N
Does food tend to get caught between your teeth?	Y	N
Are you satisfied with the appearance of your teeth?	Y	N
Are you nervous about having dental treatment?	Y	N

Are any of your teeth sensitive to: cold ❑ sweets ❑ heat ❑ other ❑ N/A ❑

Do your gums bleed when: brushing ❑ flossing ❑ N/A ❑

Have you ever had any of the following:

oral surgery ❑ periodontal treatment ❑ orthodontic treatment ❑ bite adjustment❑

bite plate ❑ other appliance ____________

Health History

Please fill out the following information to the best of your abilities.

Physician's name:
Phone Number:
Are you allergic, or have you reacted adversely, to any of the following?

Penicillin	Y	N	Tetracycline	Y	N
Erythromycin	Y	N	Aspirin	Y	N
Clindamycin	Y	N	Codeine	Y	N
Sulfa Drugs	Y	N	Darvon	Y	N
Demerol	Y	N	Mint Flavoring	Y	N
NSAIDs	Y	N	Latex	Y	N
Local Anesthetic	Y	N	Other __________________		

Please list all medication you are taking now, including non-prescription medication (vitamins, cold medications, aspirin, Tylenol, antihistamines, herbal remedies, etc.):
____

Do you have, or have you experienced, any of the following:

Allergies/Hay Fever	Y N	Other Liver Disease	Y N
Multiple Sclerosis	Y N	Psychiatric Disorder	Y N
Asthma	Y N	Kidney Disease	Y N
Parkinson's Disease	Y N	Glaucoma	Y N
Cold Sores	Y N	Artificial Joints	Y N
Lupus	Y N	AIDS/HIV	Y N
Anemia	Y N	Emphysema	Y N
Arthritis	Y N	Epilepsy	Y N
Blood Transfusion	Y N	Tuberculosis (TB)	Y N
Chronic Fatigue Syndrome	Y N	High Blood Pressure	Y N
Hemophilia	Y N	Other Lung Disease	Y N
Sexually Transmitted Disease	Y N	Scarlet Fever	Y N
Hepatitis A (infectious)	Y N	Ulcerative Colitis	Y N
Diabetes	Y N	Rheumatic Fever	Y N
Hepatitis B (serum)	Y N	Crohn's Disease	Y N
Eating Disorder	Y N	Hepatitis C	Y N
Ulcers	Y N	Drug Addiction	Y N

Heart Diseases

Angina	Y N	Stroke	Y N
Heart Murmur	Y N	Congestive Heart Failure	Y N
Mitral Valve Prolapse	Y N	Artificial Heart Valve/Stent	Y N
Angioplasty Pacemaker	Y N	Cardiopulmonary Shunt	Y N
Heart Attack	Y N	When? ____________________	

Cancer

Where? ____________________		When? ______________________	
Radiation Therapy	Y N	Chemotherapy	Y N

Do you have any disease, condition or problem not listed?	Y N
Do you wish to speak privately to the doctor about any medical condition?	Y N
Have you had a medical examination in the last year?	Y N
Have you been a patient in the hospital in the last 2 years?	Y N
When walking, do you ever stop because of pain in your chest?	Y N
Do your ankles swell during the day?	Y N
Do you have a tendency to faint?	Y N
Do you have frequent, severe headaches?	Y N
Do you use tobacco?	Y N

Are you pregnant or possibly pregnant? Y N
Are you breastfeeding? Y N

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

______________________ ______________________ ______________________
Patient Name (Print) Patient Signature Date (MM/DD/YEAR)