

FOY DENTAL CARE-Patient Registration

LAST NAME: _____ FIRST NAME: _____

MIDDLE INIT: _____ NAME CALLED: _____

STREET ADDRESS: _____ APT OR SUITE #: _____

SS#: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMAIL: _____ DATE OF BIRTH: _____

GENDER: M or F MARITAL STATUS: Single Married Divorced Widowed

EMPLOYER: _____ ETHNICITY: _____

PRIMARY INSURANCE INFO:

NAME OF INSURANCE COMPANY: _____ TELEPHONE #: _____

INSURANCE COMPANY ADDRESS: _____

NAME OF INSURED: _____ PATIENTS RELATION TO INSURED: _____

CONTRACT #: _____ GROUP #: _____ EFFECTIVE DATE: _____

SECONDARY INSURANCE INFO:

NAME OF INSURANCE COMPANY: _____ TELEPHONE #: _____

INSURANCE COMPANY ADDRESS: _____

NAME OF INSURED: _____ PATIENTS RELATION TO INSURED: _____

CONTRACT #: _____ GROUP #: _____ EFFECTIVE DATE: _____

HOW DID YOU HEAR ABOUT US? RADIO TV PHONE BOOK INTERNET DRIVING BY & SAW OUR SIGN

OR WHO MAY WE THANK FOR REFERRING YOU: _____

EMERGENCY CONTACT INFO:

NAME: _____ RELATIONSHIP TO PATIENT: _____ TELEPHONE: _____

MEDICAL HISTORY

PATIENT'S NAME: _____

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

- Are you under a physician's care now? Yes No N/A What for? _____
- Have you ever been hospitalized or had a major operation? Yes No N/A List: _____
- Have you ever had a serious head or neck injury? Yes No N/A List: _____
- Are you taking any medications, pills or drugs? Yes No N/A List: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No N/A List: _____
- Are you on a special diet? Yes No N/A _____
- Do you use tobacco? Yes No N/A How often? _____
- Do you use controlled substances? Yes No N/A List: _____

Women: Are you...

- Pregnant/Trying to get pregnant? Nursing? Taking Oral Contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Acrylic Metal Latex Local Anesthetics Other: _____

Do you have, or have you had, any of the following?

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No N/A List: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. 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 medical status.

Signature of Patient, Parent or Guardian _____ Date: _____

DENTAL HISTORY

Patient Name _____	
Date of Birth _____	Medical Alert _____

Welcome! So that we may provide you with the best possible care please complete both sides of this form. It is important that we know about your Medical and Dental History. These facts have a bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank You for taking the time to completely fill out this questionnaire.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

- | | | |
|---|-----|----|
| Hot or cold? | Yes | No |
| Sweets? | Yes | No |
| Biting or Chewing? | Yes | No |
| Have you noticed any mouth odors or bad tastes? | Yes | No |
| Do you frequently get cold sores, blisters or any other oral lesions? | Yes | No |
| Do your gums bleed or hurt? | Yes | No |
| Have your parents experienced gum disease or tooth loss? | Yes | No |
| Have you noticed any loose teeth or change in your bite? | Yes | No |
| Does food tend to become caught in between your teeth? | Yes | No |

If yes, where? _____

Do you:

- | | | |
|---|-----|----|
| Clench or grind your teeth while awake or asleep? | Yes | No |
| Bite your lips or cheeks regularly? | Yes | No |
| Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) | Yes | No |
| Mouth breathe while awake or asleep? | Yes | No |
| Have tired jaws, especially in the morning? | Yes | No |
| Smoke/chew tobacco? | Yes | No |

Have you ever had:

- | | | |
|---|-----|----|
| Orthodontic treatment? | Yes | No |
| Oral surgery? | Yes | No |
| Periodontal treatment? | Yes | No |
| Your teeth ground or the bite adjusted? | Yes | No |
| A bite plate or mouth guard? | Yes | No |
| A serious injury to the mouth or head? | Yes | No |
| If so, please describe, including cause _____ | | |

Have you experienced:

- | | | |
|--|-----|----|
| Clicking or popping of the jaw? | Yes | No |
| Pain? (joint, ear, side of face) | Yes | No |
| Difficulty in opening or closing the mouth? | Yes | No |
| Difficulty in chewing on either side of the mouth? | Yes | No |
| Headaches, neckaches or shoulder aches? | Yes | No |
| Sore muscles (neck, shoulders)? | Yes | No |

Are you satisfied with your teeth's appearance?

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment?

If so, what is your biggest concern? Yes No

Have you ever had an upsetting dental experience?

If yes, please describe _____ Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____