

Patient Registration

Patient's Name _____
Last Name First Name MI

Address _____

City _____ State _____ Zip Code _____

E Mail address _____

Sex M F Birthdate _____ Age _____ SSN# _____

Married Widowed Single Minor Separated Divorced Partnered for _____ years

Who can we thank for referring you to our office? _____

Contact Information

Phone # _____ Work Phone # _____ Ext _____ Cell Phone # _____

Best time and place to reach you _____ Appt Preference: M T W TH / AM PM

Occupation _____ Employer _____

Employer Address _____ Employer Phone _____

Spouse's Name _____ Spouse's Employer _____

Spouse's Work # _____ Spouse's E mail address _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home # (____) _____ Work # (____) _____ Cell # (____) _____

Dental History

Reason for visit _____ Chew on one side of mouth Yes No Mouth breathing Yes No

Previous Dentist _____ Cigarette, cigar or pipe smoking Yes No Mouth pain when brushing Yes No

City/State _____ If so, how much _____ Orthodontic treatment Yes No

Last Dental Visit _____ Clicking or popping jaw Yes No Pain around ear Yes No

Date of last Dental X-rays _____ Dry mouth Yes No Periodontal treatment Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following: Embedded foreign objects Yes No Sensitivity to cold Yes No

Bad Breath Yes No Fingernail biting Yes No Sensitivity to heat Yes No

Bleeding Gums Yes No Food collection between teeth Yes No Sensitivity to sweets Yes No

Blisters on lip or mouth Yes No Grinding teeth Yes No Sensitivity when biting Yes No

Burning Sensation on tongue Yes No Gums swollen or tender Yes No Sores or growths in your mouth Yes No

Are there any dental conditions, which you have had that are not listed? Yes No

If yes, please list _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Health History

Physician's Name _____ Phone # _____

Date of last visit _____ Reason for visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include Ionimin, Adipex, Fastin, Pondimin and Redux. Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | | | | | | | | | |
|---|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Artificial Heart Valves | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding abnormally,
with extractions or surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Back Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Circulatory Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congestive Heart Lesions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumor or growth on
head or neck | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cough, persistent
or bloody | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | | | Nervous Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weight Loss,
unexplained | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | | | Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| | | | Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Do you wear contact lenses? Yes No

WOMEN

- Are you pregnant? Yes No Due Date _____
- Are you nursing? Yes No
- Taking birth control pills? Yes No

Medications

List any medications you are currently taking and the reason for the medication.

Pharmacy name _____ Phone # _____

Allergies

I have no know allergies to any medications or foods. Please initial _____ Date _____

Please mark all of the following to which you are allergic :

- | | | | |
|--|---|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa | _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetic | | _____ |

I understand that Dr Corbet's knowledge of my dental and health history, the medications I take and any known allergies are important for the proper diagnosis and treatment of any dental conditions. To the best of my knowledge, the above information is complete and correct.

Signature of patient, parent, guardian or personal representative

Date