Atlantic DENTAL GROUP
Comprehensive & Esthetically-Driven Dentistry

Patient Registration and Health History

Patient Information – *Tell us about yourself*

First Name: _____ Last Name: _____ Middle Initial: ____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____ Text Msg: Y / N

Sex (select): Male Female Marital Status (select): Married Single Divorced Separated Widowed

Birth Date: _____ Social Security #: _____ Driver's License: _____

Email:_____ I would like to receive email appointment reminders & correspondence: Y / N

Employment Status (select one): Full Time Part Time Retired Other Employer: _____

Student Status (select one): Full Time Part Time Name of School/College_____

How did you hear about Atlantic Dental Group: _____

Insurance Information – *Let us know if we will be filing insurance on your behalf*

Primary Dental Insurance Co:_____ Group #: _____ ID #: _____

Insurance Co Address: _____ Insurance Co Phone: _____

Name of Insured: _____ Relationship to Insured (select): Self Spouse Child Other

Insured Social Security #: _____ Insured Birth Date: _____ Employer _____

Secondary Dental Insurance Co:_____ Group #: _____ ID #: _____

Insurance Co Address: _____ Insurance Co Phone: _____

Name of Insured: _____ Relationship to Insured (select): Self Spouse Child Other

Insured Social Security #: _____ Insured Birth Date: _____ Employer _____

Account Information / Responsible Party – *Who is responsible for any account balance?*

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Birth Date: _____ Social Security #: _____ Driver's License: _____

In the Event of An Emergency – *Whom should we contact?*

Name: _____ Relationship to Patient: _____ Phone: _____

Patient Name _____ Birth Date_____ Today's Date_____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

If patient is under 18, please complete the ADA Child Health/Dental History Form instead of the next two pages.

Dental History

Y / N Do your gums bleed when you brush or floss?
Y / N Are your teeth sensitive to cold, hot, sweets or pressure?
Y / N Does food or floss catch between your teeth?
Y / N Is your mouth dry?
Y / N Have you had any periodontal (gum) treatments?
Y / N Have you ever had orthodontic (braces) treatment?
Y / N Have you ever had any problems associated with previous dental treatment?
Y / N Is your home water supply fluoridated?
Y / N Do you drink bottled or filtered water?
Y / N Are you experiencing any dental pain or discomfort?
Y / N Do you have earaches or neck pains?
Y / N Do you have any clicking, popping or discomfort in the jaw?
Y / N Do you brux or grind your teeth?
Y / N Do you have sores or ulcers in your mouth?
Y / N Do you wear dentures or partials?
Y / N Do you participate in active recreational activities?
Y / N Have you ever had a serious injury to your neck, head or mouth? _____
Y / N Has a physician or dentist ever recommended that you take antibiotics prior to your dental treatment?

Date of your last dental exam and what was done at that time: _____

Date of last dental x-rays: _____

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

Joint Replacements, Transplants and Pre-Medication Requests

Y / N Have you ever had an orthopedic total joint (hip, knee, elbow, finger) replacement? If yes, please provide the date and explanation of which joint.

_____

Y / N Have you had any complications from the joint replacement?
Y / N Do you have an artificial heart valve? _____
Y / N Have you had previous infective endocarditis?
Y / N Have you had damaged valves in a transplanted heart? _____
Y / N Has a physician or dentist recommended that you take antibiotics prior to your dental treatment?
If yes, name of doctor making that recommendation: _____

Allergies

Are you allergic to any of the following (please select all that apply):

Aspirin	Penicillin	Sulfa Drugs	Codeine	Other Narcotics	Barbiturates	Sedatives
Sleeping Pills	Local Anesthetics	Acrylic	Metal	Latex	Iodine	Hay Fever

Other (including animals and foods): _____

_____

Patient Name_____ Birth Date_____ Today's Date_____

Medical History

Y / N Have you been out of the country in the last 30 days?

Y / N Are you under a physician's care now? Please explain & physician's name: _____

Y / N Has there been any change to your general health within the past year: _____

Y / N Have you ever been hospitalized or had a major operation? _____

Y / N 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): _____

_____

Y / N Do you take, or have you taken, Phen-Fen or Redux?

Y / N Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? _____

Y / N Are you on a special diet? _____

Y / N Do you drink alcoholic beverages? How much per week? _____ How much in the last 24 hrs? _____

Y / N Do you use tobacco products of any type? If so, what products: _____

Y / N Do you use controlled substances? _____

Women:

Y / N Are you pregnant or trying to get pregnant? If yes, how many weeks? _____

Y / N Are you taking birth control or hormonal replacements? _____

Y / N Are you nursing?

Have you had, or do you have, any of the following? (continued on next page)

Nervous System Disorders

Y / N Headaches / Migraines
Y / N Seizures / Epilepsy
Y / N Strokes / TIAs
Y / N Cerebrovascular Accidents
Y / N Syncope / Fainting
Y / N Neuropathy
Y / N Drug Abuse
Y / N Drug Addiction
Y / N Anxiety
Y / N PTSD
Y / N Depression / Anti-depressants
Y / N Alzheimer's Disease
Y / N Memory Loss
Y / N Eating Disorders
Y / N Psychiatric Care
Y / N Other Mental Health Disorders

_____

Respiratory / Lung Disorders

Y / N COPD
Y / N Emphysema
Y / N Asthma
Y / N Smoking
Y / N Obstructive Sleep Apnea
Y / N Sleep Disorder
Y / N Easily Winded (Dyspnea) on Exertion
Y / N Chronic Cough / Wheezing
Y / N Bronchitis
Y / N Lung Disease (other)

_____

Cardiovascular / Heart Disorders

Y / N Hypertension / High Blood Pressure
Y / N Hypotension / Low Blood Pressure
Y / N Heart Valve Disease
Y / N Valve Replacement
Y / N Heart Murmur
Y / N Pacemaker
Y / N Mitral Valve Prolapse (MVP)
Y / N Irregular Heartbeat / Dysrhythmia
Y / N Myocardial Infection (MI)
Y / N Angina / Chest Pain
Y / N Congestive Heart Failure (CHF)
Y / N Coronary Artery Bypass Graft (CABG)
Y / N Deep Vein Thrombosis (DVT)
Y / N Bleeding Disorders / Excessive Bleeding
Y / N Blood Thinners (Aspirin, Plavix, Warfarin)
Y / N Anemia
Y / N Hemophilia
Y / N Congenital Heart Disorder
Y / N Sickle Cell Anemia
Y / N Endocarditis History
Y / N Scarlet / Rheumatic Fever
Y / N Cardiovascular Disease (other)

_____

Musculoskeletal Disorders

Y / N Joint Pain
Y / N Rheumatoid Arthritis
Y / N TMJ Disorder / Pain
Y / N Osteoporosis
Y / N Biophosphonates
Y / N Neck / Back Pain
Y / N Muscle Weakness
Y / N Degenerative Joint Disease (DJD)
Y / N Artificial Joint
Y / N Bone / Muscle Issues (other)

_____

Patient Name_____ Birth Date_____ Today's Date_____

Have you had, or do you have, any of the following? (continued from prior page)

Gastrointestinal (GI) Disorders

Y / N Peptic Ulcer Disease (PUD)
Y / N GERD / Reflux / Heartburn
Y / N Barrett's Esophagus
Y / N Chron's Disease
Y / N Ulcerative Colitis
Y / N Alcohol Abuse / Dependency
Y / N Hepatitis A
Y / N Hepatitis B or C
Y / N Yellow Eye Sclera (Jaundice)
Y / N Grapefruit Juice Intake

Genitourinary Disorders

Y / N Chronic Kidney Disease (CKD)
Y / N Renal Insufficiency
Y / N Dialysis
Y / N Nephrolithiasis (Kidney Stones)
Y / N Urinary Dysfunction
Y / N Erectile Dysfunction or Medication
Y / N Benign Prostate Hyperplasia (BPH)
Y / N Genitourinary Disorders (other)

_____

Y / N Sexually Transmitted Disease

Recent Symptoms

Y / N Fever / Chills
Y / N Nausea / Vomiting
Y / N Weight Change
Y / N Blurry Vision
Y / N Headaches / Migraines
Y / N Trauma
Y / N Rash / Hives / Skin Issues

Endocrine Disorders

Y / N Thyroid / Parathyroid Disorders
Y / N Diabetes Insipidus
Y / N Diabetes Mellitus Type 1 (DM1)
Y / N Diabetes Mellitus Type II (DM2)
Y / N Chronic Steroid Therapy
Y / N Hypoglycemia

Other

Y / N Cancer
Y / N Chemotherapy
Y / N Head and Neck Radiation
Y / N Glaucoma
Y / N Myasthenia Gravis
Y / N HIV / AIDS
Y / N Tuberculosis
Y / N Eczema
Y / N Anaphylaxis
Y / N Herpes Simplex Virus (HSV)
Y / N Cold Sores / Fever Blisters
Y / N Blood Transfusion
Y / N Leukemia
Y / N Systemic Lupus Erythematous (SLE)
Y / N Recurrent Infections
Y / N Persistent Swollen Lymph Nodes
Y / N Oral Ulcers
Y / N Shingles
Y / N Tumors / Growths
Y / N Hay Fever
Y / N Tonsillitis

Comments regarding any of the above:

_____

_____

_____

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.

_____ _____ _____
Printed Name Signature Date

If personal representative signs this authorization on behalf of the individual, please complete the following:

_____ _____ _____
Representative's Name (Please Print) Signature Relationship to Individual