Patient Registration

☐Mr. ☐Mrs. ☐Ms. ☐Dr. First Name _____________________ M.I. _____ Last Name
____

Sex: ☐Male ☐ Female Birth Date _____________ Age _____ Social Security Number
____

Street ____ Apt. ______ City ________________ State _____ Zip________

Home Tel. (_____)_________________ Cell (_____)_________________ Work (_____)_________________

Employer ____ Email ______________________________________

Referred By ________________________Dentist _______________________ Orthodontist _______________________

Medical Dr. ________________________ **Marital Status:** ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Legally Separated

In case of emergency, please contact _______________________ Tel. (_____)______________ Relation _____________

PARENT OR GUARDIAN RESPONSIBLE FOR PATIENT

☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other
____

Name _________________________________ S.S. # ______________________ Birthdate _____________ Age _______

Home Tel. (_____)_________________ Cell (_____)_________________ Work (_____)_________________

Employer ____ Email ____

Street ____ Apt. ______ City ________________ State _____ Zip________

Signature of Responsible Party____

Health History Form

Patient's Name ______________________________________ Date of Birth _____/_________/___________

Gender: ________________________ Height: _________ Weight: __________

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: ____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe: ____

Are you now under a doctor's care for a particular problem at this time? Yes No

If yes, why? _______________________________________ Date of last physical exam ____/______/_________

Have you ever been hospitalized or had a serious illness? Yes No
If yes, why?____

Have you ever had surgery? Yes No
If yes, when and what for? Date of surgery:______________ Reason for surgery:_______________________________________
Date of surgery:______________ Reason for surgery:_______________________________________

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Condition	Yes	No	Condition	Yes	No
Congenital heart disease, cardiovascular disease, heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker?	Yes	No	Lung disease, asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Arthritis	Yes	No
Stomach ulcers, acid reflux colitis?	Yes	No	Significant weight loss or gain?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Glaucoma?	Yes	No	Sleep apnea?	Yes	No
Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any cancer, radiation, or chemotherapy? Yes No
Describe: _____________________________________Date of your last treatment? ______________________

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: ____

Health History Form

Patient's Name ____ Date of Birth _____/_________/___________

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

MEDICATIONS

Are you using any of the following:

Antibiotics? Yes No

Anticoagulants (blood thinners)? Yes No

Heart medications? Yes No

Steroids (cortisone, prednisone, etc.)? Yes No

Antianxiety agents, antidepressants or other psychiatric medications? Yes No

Prescription pain medication? Yes No

Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Yes No

Insulin or oral anti-diabetic drugs? Yes No

Blood pressure medications? Yes No

Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use. Yes No

____

____

Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	Dosage	Medication	Dosage

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex? Yes No

Food allergies (nuts, eggs)? Yes No

Sedatives, barbiturates? Yes No

Codeine or other pain killers? Yes No

Aspirin, Motrin, Aleve, or ibuprofen? Yes No

Penicillin or other antibiotics? Yes No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? ______________ Relationship? _________________

Other drug or food allergies not listed above: ____

Health History Form

Patient's Name ______________________________________ Date of Birth _____/_________/___________

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes No If yes, for how long? ______________________________________

Have you ever sought professional care or been hospitalized for:

Substance abuse? Yes No
Emotional disorders? Yes No
Alcoholism? Yes No

Do you use:

Alcohol? Yes No How often? ____________
Marijuana? Yes No How often? ____________
Recreational drugs? Yes No How often? ____________

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?_________________________________
____

Do you wish to talk to the doctor privately about anything? Yes No

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes? Yes No Relationship ______________ Cancer? Yes No Relationship _____________

Heart disease? Yes No Relationship ______________ Bleeding problems? Yes No Relationship _____________

Sleep Apnea? Yes No Relationship ______________ Lung disease? Yes No Relationship ____________

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

____ ____
Signature of patient, parent, guardian Date

____
Printed name of patient, parent, guardian/Relationship

I authorize Dr. Lisa Miller and team to perform an oral and maxillofacial examination for the aim of diagnosing and treatment planning. Furthermore, I authorize the taking of all x-rays needed as a necessary a part of this examination. Additionally, if medically necessary, I authorize the discharge of any data obtained within the course of my examination and treatment to my alternative doctors and/or insurance carriers.

____ ____
Signature of patient, parent, guardian Date

Insurance Information

Please present your medical and dental insurance cards at your appointment. **If complete insurance information is not provided at time of service, payment will be expected in full.**

Dental Insurance

Primary Insurance Co. Name ____

Subscriber's Name (Policy Holder) ____
First Name Last Name

Address and Phone # of Subscriber ______________________________ (____) ____________

Subscriber's Social Security # ______________________________ Birthdate ______________

Contract or ID # ______________________________ Group # ______________

Secondary Insurance Co. Name ____

Subscriber's Name (Policy Holder) ____
First Name Last Name

Address and Phone # of Subscriber ______________________________ (____) ____________

Subscriber's Social Security # ______________________________ Birthdate ______________

Contract or ID # ______________________________ Group # ______________

Medical Insurance

Primary Insurance Co. Name ____

Subscriber's Name (Policy Holder) ____
First Name Last Name

Address and Phone # of Subscriber ______________________________ (____) ____________

Subscriber's Social Security # ______________________________ Birthdate ______________

Contract or ID # ______________________________ Group # ______________

Secondary Insurance Co. Name ____

Subscriber's Name (Policy Holder) ____
First Name Last Name

Address and Phone # of Subscriber ______________________________ (____) ____________

Subscriber's Social Security # ______________________________ Birthdate ______________

Contract or ID # ______________________________ Group # ______________