ATLANTIC
DENTAL
WELLNESS

New Patient Registration and Health Form

Patients Name________________________ Date____________

Mailing Address________________ City____________ State_____ Zip________

Sex: M F Age__________ Birth Date______________ SS#____________

Home Phone____________ Work Phone____________ Cell Phone____________

Email________________ (circle one) Single Married Widow Separated Divorced

Patients Employer/School________________ Occupation____________

Employer/School Address________________ Phone____________

Referral Source: Who can we thank for referring you? ________________________

Insurance Information

Primary Insurance

Name of Responsible Party____________ Birth Date__________ SS#__________

Relationship to Patient__________ Insurance Co.__________ Group #__________

Employer______________ Address________________________

Secondary Insurance (If Applicable)

Name of Responsible Party____________ Birth Date__________ SS#__________

Relationship to Patient__________ Insurance Co.__________ Group #__________

Employer______________ Address________________________

Main Problems/ Reasons for this Appointment

Please list some of the problems or questions you would like to speak to the doctor about.

1.____

2.____

3.____

Additional problems or concerns you would like addressed

____

____

Dental History

Date of last dental cleaning________________________ Date of last dental x-rays taken________________________

How often do you brush your teeth________________ How often do you floss________________________________

Do you think you have active tooth decay or gum disease? Yes No
Have you ever had gum treatment or surgery? Yes No
If yes, when? ________________________ and where? ___________________________

Do your gums bleed? Yes No
Do you have any loose teeth? Yes No
Do you have clicking, popping, or discomfort in the jaw joints? Yes No
Do you grind or clench your teeth? Yes No
Do you smoke or chew tobacco? Yes No
Do you have any tongue or lip piercings? Yes No
Have you ever had or do you presently wear braces? Yes No
Do you presently wear a removable partial or denture? Yes No
Do you have sensitivity to hot? Yes No
Do you have sensitivity to cold? Yes No
Do you have sensitivity to sweets? Yes No
Do you have sores or growths in your mouth? Yes No
Do you have problems with food collection between teeth? Yes No

Health History

Date of last health care exam____________________________ What was this exam for?________________________

Have you been hospitalized in the last 5 year? Yes No
If yes, reason____

Are you currently receiving care? Yes No

<u>Please list ALL the names and phone numbers of the physicians who are currently providing you care.</u>

1.____ 3.____

2.____ 4.____

WOMEN: Are you pregnant? Yes No -If yes, what is your due date____________________
Are you currently breast feeding? Yes No
Are you taking oral contraceptives? Yes No

Please mark yes or no to indicate if you have had any of the following.

Condition			Condition			Condition		
Chest Pain	Yes	No	Shortness of Breath	Yes	No	Hives or Skin Rash	Yes	No
Heart Failure	Yes	No	Ulcers	Yes	No	Alcoholism	Yes	No
Heart Disease or Attack	Yes	No	Mental Retardation	Yes	No	Herpes	Yes	No
Angina Pectoris	Yes	No	Emphysema	Yes	No	Glaucoma	Yes	No
Heart Problems	Yes	No	Fainting or dizzy spells	Yes	No	*Steroid Treatment	Yes	No
Liver Disease	Yes	No	Eating Disorder	Yes	No	Arthritis	Yes	No
Heart Surgery	Yes	No	Epilepsy or Seizures	Yes	No	*Any type of implant	Yes	No
High Blood Pressure	Yes	No	Persistent Cough	Yes	No	Cancer	Yes	No
*Heart Murmur	Yes	No	Tuberculosis (TB)	Yes	No	Birth Defects	Yes	No
*Rheumatic Fever	Yes	No	Asthma	Yes	No	HIV Positive, ARC, AIDS	Yes	No
Psychiatric Treatment	Yes	No	*Congenital Heart Prob.	Yes	No	Hay Fever	Yes	No
Sickle Cell Disease	Yes	No	Hepatitis A (Infectious)	Yes	No	Use of tobacco products	Yes	No
Sinus Trouble	Yes	No	Hepatitis B (Serum)	Yes	No	Bruise easily	Yes	No
*Artificial Joints	Yes	No	Hepatitis C or other	Yes	No	Jaundice	Yes	No
Thyroid Disease	Yes	No	Heart Pacemaker	Yes	No	Heart Surgery	Yes	No
Anemia	Yes	No	Stroke	Yes	No	Kidney Trouble	Yes	No
Blood Transfusion	Yes	No	Drug Addiction	Yes	No	Hemophilia	Yes	No
*Any type of transplant	Yes	No	Cold Sores	Yes	No	Diabetes	Yes	No
*Mitral Valve Prolapse	Yes	No	Radiation Therapy	Yes	No	Chemotherapy	Yes	No

Antibiotic pre-medication may be required prior to your appointment

Are you required to Pre-Medicate before dental treatment? Yes No

Are you ALLERGIC or have you ever experienced any reaction to the following?

Item			Item		
Local Anesthetics (novocaine)	Yes	No	Aspirin or codeine	Yes	No
Barbiturates/sedatives/ sleeping pills	Yes	No	Sulfa drugs	Yes	No
Penicillin/ other antibiotics	Yes	No	Others____________________		

Medications : Are you taking any of the following?

Medication			Medication		
Antibiotics/sulfa drugs?	Yes	No	Tranquilizers	Yes	No
Blood thinners	Yes	No	Insulin/other diabetes drugs	Yes	No
Blood pressure medication	Yes	No	Digitalis/other heart drugs	Yes	No
Thyroid medication	Yes	No	Nitroglycerin	Yes	No
Cortisone/steroids	Yes	No	Aspirin	Yes	No
Recreational drugs	Yes	No	Antihistamines/allergy drugs	Yes	No
Antacids	Yes	No	Tagamet (Cimetidine)	Yes	No

Current Medications	Dose	Times/Day

Current Herbs/ Vitamins/ Supplements	Dose	Times/Day

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (print name) _______________ Patient Signature _______________ Date _______________

DOCTOR'S USE ONLY!

Comments on patient interview concerning medical history: _______________

Significant findings from questionnaire or oral interview: _______________

Doctor (print name) _______________ Doctor Signature _______________ Date _______________

Health History Update

Note changes below	Patient Signature	Date