# PATIENT REGISTRATION 2015

**Uptown Dentistry**

Date _____

Patient Name _____ Preferred Name _____ DOB _____
First Middle Last

SS# _____ DL# _____ Occupation _____ Work # (____) _____

Marital Status: Single___ Married___ Divorced___ Widowed___ Spouses Name: _____

Street Address _____ City: _____ State: _____ Zip _____

Home Number (____) _____ Cell Phone (___) _____

E- Mail Address _____

Employer Name _____

Person Responsible for Account _____ Relationship _____

Social Security # _____ DL# _____ Home # (___) _____

Home Address (if different) _____ Zip _____

Do you have Dental Insurance? Yes_____ No If yes, with Whom? _____

Policy Holder Name: _____ ID Number: _____

Claims Address _____

Insurance (provider) Phone Number: _____

Who Referred You to Our Office: _____ Physician: _____

Emergency Contact _____ Relationship _____ Phone _____

Are you currently having dental problems? _____

_____

What are your concerns? *Circle as many as applicable:* Pain Avoidance Appearance Losing Teeth Gum/Periodontal Disease Cavities Oral Cancer Wasting/Exceeding Dental Insurance Benefits Your General Health Routine Checkup Cleaning

Other: _____

**Circle yes or no to the following questions:**

1. Are you presently under the care of a physician? ..... Yes No
2. Have you ever had high blood pressure? ..... Yes No
3. Has a physician ever said you had heart trouble? ..... Yes No
4. Do you have Mitral Valve Prolapse? ..... Yes No
5. Have you ever had abnormal bleeding following a cut or extraction? ..... Yes No
6. Do you require **pre-medication (antibiotics) prior to dental procedures**? ..... Yes No
7. Has a physician or dentist ever said you had a tumor or cancer? If so, explain _____ Yes No

   _____
8. Are you allergic to Penicillin, Novocain or any other medicine? ..... Yes No
   If so, what? _____
9. Is the patient allergic to anything other than medicine? (e.g. latex or metals)? ..... Yes No
   If so, what? _____

**Do you have or ever had:**

1. Artificial join/prosthesis? Yes No
2. Heart disease? ..... Yes No
3. Anemia, leukemia or low platelets ..... Yes No
4. Epilepsy or seizures? ..... Yes No
5. Asthma or hay fever? ..... Yes No
6. Tuberculosis ..... Yes No
7. Diabetes? How long? ..... Yes No
8. Kidney trouble? ..... Yes No
9. Liver trouble or jaundice? ..... Yes No
10. Thyroid trouble or goiter? ..... Yes No
11. Venereal Disease? ..... Yes No
12. Fainting or dizziness? ..... Yes No
13. Sleep Apnea? ..... Yes No
14. Arthritis? ..... Yes No
15. HIV/AIDS? ..... Yes No
16. Stroke? ..... Yes No
17. Stomach ulcer? ..... Yes No
18. Heart murmur? ..... Yes No
19. Do you smoke? ..... Yes No
20. Hepatitis? ..... Yes No
21. Allergies or hives? ..... Yes No
22. Psychiatric treatment? ..... Yes No
23. Are you pregnant? ..... Yes No
24. Do you take birth control? Yes No

**Are you now taking:**

1. Drugs for high blood pressure? ..... Yes No
2. Drugs for sleep? ..... Yes No
3. Cortisone, steroids or ACTH? ..... Yes No
4. Anticoagulants or blood thinner? ..... Yes No
5. Tranquilizers or sedatives? ..... Yes No
6. Antibiotics? ..... Yes No
7. Insulin? ..... Yes No
8. Medication for bone loss (Bisphosphonate)? ..... Yes No
9. Vitamins, natural products or herbal supplements? Yes No
10. List any current medications: _____

_____

_____

11. Have you been under the care of a physician for any **major illness** or injury other than those noted above. If so, list.

_____

**I Understand That Payment Is Due At Time Of Service.**

**I will pay today by: CASH ❑ CHECK ❑ CREDIT CARD ❑**

**CARE CREDIT ❑**

**Signature** _____ **Date** _____

*Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA.*