ADVANCED DENTAL CENTER PA

CONFIDENTIAL PATIENT REGISTRATION AND MEDICAL HISTORY

Patient Name _____ Birthday ____/____/____ Age _____
Last First Middle

Mailing Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work (____) _____ Cell (____) _____

Male ( ) Female ( ) SSN # _____-_____-_____ email _____

Where do you work ? _____ How long ? _____

Spouse's Name _____ DOB _____ Workplace _____

Emergency Contact person and Phone Number _____ Relation _____

Whom may we thank for referring you, or what attracted you here ? _____

Financially Responsible Party _____ Social Security Number _____-_____-_____

Name of Insurance Co. _____ Policy # _____

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I authorize Advanced Dental Center PA to release any information pertaining to this patient's treatment to my insurance companies. I authorize all insurance payments to go directly to Advanced Dental Center PA. I understand that I am responsible for any fees not paid by my insurance company. I agree to pay any account balance that is over 60 days past due regardless of insurance status. In the event that this account must be released for collection, any collection and/or attorney fees will be borne by the account.

Signature of Financially Responsible Party _____

Dentist _____ Medical Doctor _____ Last Physical _____ Pharmacy _____

1) What is your chief reason for being here ? _____
2) What would you like to change about your smile ? _____
3) Past Medical History
   a. Have you ever been treated poorly by a dentist ? _____
      Would you prefer cosmetic fillings to silver mercury fillings Y N Do you desire whiter teeth ? Y N
      Have you ever responded adversely to medical or dental treatments ? Y N Do you need calming medicine ? Y N
   b. Are you allergic to any Medications, Latex, or Eggs ? _____/_____/_____
   c. Do you smoke or chew tobacco ? Y N. If yes, how much per day ? _____ How long ? _____
   d. Do you use alcohol ? Y N. Do you use street drugs ? Y N. If yes, what and how much _____
   e. **Women:** Are you possibly pregnant ? Y N
   f. Have any family members been patients here ? _____

3) Medications (List name and dosage below)

____ B/P or Heart Medicine _____
____ Steroids (Prednisone) _____
____ Insulin _____
____ Blood Thinners (Coumadin) _____
____ Antibiotics _____
____ Pain Medicine _____
____ Bone Density Medicines **Past** or **Present** ?
(Fosamax, Boniva, Actonel, Aredia, Zometa, Skelid
Didronel, Reclast)
____ Herbal Remedies (Ginko, Ginseng, St. Johns Wort)

Other Medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

- OVER -

4) Review of Systems. Do you or a family member have a history of any of the following problems ?

	PATIENT YES	PATIENT NO	FAMILY YES	FAMILY NO	Explanation
A. HEART					
Heart Attack or Disease	___	___	___	___	_____
Heart Surgery (bypass or valve)	___	___	___	___	_____
Heart Murmur	___	___	___	___	_____
Angina or Chest Pain	___	___	___	___	_____
Coronary Artery Disease	___	___	___	___	_____
Congestive heart Failure	___	___	___	___	_____
High Blood Pressure	___	___	___	___	_____
Rheumatic Fever	___	___	___	___	_____
Heart Cath	___	___	___	___	_____
Pacemaker	___	___	___	___	_____
Fainting Spells	___	___	___	___	_____
B. LUNGS					
Tuberculosis	___	___	___	___	_____
Asthma	___	___	___	___	_____
Bronchitis / Pneumonia	___	___	___	___	_____
Emphysema	___	___	___	___	_____
C. GASTROINTESTINAL					
Hepatitis	___	___	___	___	_____
Stomach Ulcers	___	___	___	___	_____
Liver Disease / Jaundice	___	___	___	___	_____
D. ENDOCRINE					
Diabetes	___	___	___	___	_____
Thyroid Problems	___	___	___	___	_____
Kidney Problems	___	___	___	___	_____
E. NERVOUS SYSTEM					
Stroke	___	___	___	___	_____
Seizures or Epilepsy	___	___	___	___	_____
Psychiatric (depression, anxiety, ect.)	___	___	___	___	_____
F. OTHER					
Glaucoma	___	___	___	___	_____
TMJ disorder (current or previous treatment)	___	___	___	___	_____
Cancer or Chemotherapy	___	___	___	___	_____
Artificial Joints / Implants / Transplants	___	___	___	___	_____
Osteoporosis	___	___	___	___	_____
Bleeding Disorder (free bleeder)	___	___	___	___	_____
Anemia or Sickle Cell Disease	___	___	___	___	_____
Venereal Disease (STD, VD, bad blood)	___	___	___	___	_____
HIV / AIDS	___	___	___	___	_____

Are there any other medical conditions the doctor should be aware of ?_____
If you have any questions or concerns about any medical condition, discuss it with the doctor.

To the best of my knowledge, all the information on this record is true and correct. I have not intentionally withheld any information. ***I will inform the doctor at each appointment of any changes in my condition or medications.***

Patient's Signature_____ Date _____
(Parent or Guardian if under 18)

Reviewer's Signature_____ Date _____