DUNELAND DENTAL GROUP

PATIENT REGISTRATION & HEALTH HISTORY FORM

Please Complete the Following Confidential Information:

PATIENT INFORMATION — *CONFIDENTIAL*

Patient Name: _____
first middle last

Address: _____
street apt. city state zip

Telephone: home _____ cell _____ work _____

E-mail: _____ **Birth date:** _____ **Soc. Sec. #:** _____

Patient's Employer if not the same as responsible party: _____

Sex: (✓ check one) ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single ☐ Widowed ☐ Divorced

RESPONSIBLE PARTY INFORMATION

Same as Patient: ☐ yes

Name of person responsible for this account: _____
first middle last

Address: _____
street apt. city state zip

Telephone: home _____ cell _____ work _____

Social Security Number: _____ **Birth Date:** _____

Employer: _____
name address city state zip

PRIMARY DENTAL INSURANCE INFORMATION

Member name _____
Birth Date Social Security

_____
phone number address city state zip

Employer: _____
name address city state zip

Dental Insurance Company: _____
name Phone group number

SECONDARY DENTAL INSURANCE INFORMATION

Member name _____
Birth Date Social Security

_____
phone number address city state zip

Employer: _____
name address city state zip

Dental Insurance Company: _____
name Phone group number

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IN CASE OF EMERGENCY

PERSON TO CONTACT:

name | home phone | cell phone

DENTAL INFORMATION *For the following questions, please mark (X) your responses.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam: _____
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?

MEDICAL INFORMATION *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam: _____

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

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 dietary supplements:

_____

_____

_____

_____

_____

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: Phone: *Include area code* ( )

Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

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MEDICAL INFORMATION

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total join (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping?			
Circle one: VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all yes responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever / seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent infections	☐	☐	☐
Type of infection _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

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Do you have any preferences as to how we contact you- via email _____

or text message _____

Whom may we thank for referring you? _____

FINANCES

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you.

☐ Cash ☐ Check ☐ Credit Card

Interest Free Financing is also available upon approval through the following:

☐ Care Credit

If you are considering financing, please ask one of our financial coordinators for an application.

Consent: As the undersigned, I hereby authorize Doctor to, after thorough explanation, take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by doctor to make a diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated (after they are discussed with me) and further authorize and consent that Doctor choose and employ such assistance as he/she deems fit. I also understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine, due and payable at the time services are rendered. Although Duneland Dental Group will process insurance claims at no charge, I am responsible for any and all charges not covered by the insurance company. There is a $25.00 Service Charge for any non-sufficient fund check. If the account becomes past due, and legal action is taken, I will be responsible for all expenses, including court costs, attorney fees and interest. I also understand that there may be a fee for cancelled appointments without a 24 hour notice.

Signature of Patient, Parent or Responsible Party: X _____

Date: _____ Relationship to Patient: _____

If you have any questions or concerns please feel free to contact our office at 219-926-7595, and or send us an email at info@dunelanddental.com. Please like us on our facebook page and look for our monthly promotions.

We value all our patient's comments and feedback.