AARON S. CLARK DDS **ALEX J. VANOVERLOOP DDS**

PATIENT REGISTRATION FORM

PATIENT_____ BIRTH DATE_____ SOCIAL SECURITY #_____

HOME ADDRESS_____ CITY_____ STATE_____ ZIP_____

CELL PHONE_____ HOME_____ EMAIL_____

EMPLOYER_____ BUSINESS PHONE_____

IN CASE OF EMERGENCY, NOTIFY_____ PHONE_____

DENTAL INSURANCE COMPANY_____EMPLOYER _____

SUBSCRIBER ID/POLICY NUMBER_____GROUP NUMBER_____

IF YOUR SPOUSE HAS DENTAL INSURANCE, ARE YOU ALSO COVERED UNDER THAT POLICY? ___ SPOUSE'S SOC. SEC.#_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PATIENT MEDICAL HISTORY

YES / NO ARE YOU IN GENERAL GOOD HEALTH AT THIS TIME?
YES / NO ARE YOU CURRENTLY UNDER MEDICAL TREATMENT? IF SO, FOR WHAT?_____
YES / NO HAVE YOU HAD ANY MAJOR OPERATIONS? IF SO, WHAT?_____
YES / NO HAVE YOU HAD ANY HEAD INJURIES? IF SO, WHAT and WHEN?_____
YES / NO HAVE YOU HAD AN ALLERGIC REACTION TO ANYTHING SUCH AS LATEX OR PENICILLIN? IF SO, WHAT?_____
YES / NO ARE YOU TAKING ANY MEDICATION? LIST MEDICATIONS:_____

_____

YES / NO DO YOU TAKE ASPIRIN DAILY?
YES / NO ARE YOU TAKING ANY STEROIDS, INCLUDING CORTISONE?
YES / NO HAVE YOU EVER NEEDED TO TAKE AN ANTIBIOTIC PRIOR TO DENTAL TREATMENT? IF SO, WHY?_____
YES / NO WOMEN: ARE YOU PREGNANT? IF SO, HOW FAR ALONG?_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

ACID REFLUX
ADHD/ADD
AIDS
ALZHEIMERS
ANEMIA
ANGINA PECTORIS (CHEST PAIN)
ANXIETY
ARTIFICIAL JOINT:
WHERE_____
WHEN_____
ARTIFICIAL HEART VALVE
ARTHRITIS
ASTHMA
AUTISM
BLOOD PRESSURE: High or Low
CANCER: TYPE:_____
WHEN: _____
CHEMOTHERAPY
HIGH CHOLESTEROL
COLD SORES
DENTAL IMPLANTS
DEPRESSION
DIABETES: Type I or Type II
DRUG ADDICTION
EMPHYSEMA
EPILEPSY OR SEIZURES
FAINTING OR DIZZINESS
HEART ATTACK
HEART DISEASE
HEART MURMUR
HEART SURGERY
HEMOPHILIA
HEPATITIS: A, B, or C
HIV POSITIVE
HYDROCEPHALUS
KIDNEY DISEASE
MITRAL VALVE PROLAPSE
PAIN IN JAW JOINTS
PACEMAKER
RADIATION TREATMENT
WHEN: _____
RHEUMATIC FEVER
SINUS TROUBLES
SEASONAL ALLERGIES
STROKE
STENTS
THYROID DISEASE: Hypo/Hyper
TUBERCULOSIS
VENEREAL DISEASE
OTHER: _____

PATIENT DENTAL HISTORY

DATE OF LAST DENTAL EXAM/XRAYS_____PREVIOUS DENTIST_____
WHAT IS YOUR REASON FOR SEEKING DENTAL CARE TODAY? _____
DO YOU SMOKE OR USE SMOKELESS TOBACCO PRODUCTS? YES / NO
HOW MANY SWEETENED DRINKS (POP, JUICE, ENERGY DRINKS, TEA, COFFEE, ETC...) DO YOU DRINK A DAY? _____
HAVE YOU EXPERIENCED ANY GROWTH OR SORE SPOTS IN YOUR MOUTH? IF SO WHERE? _____
DOES ANY PART OF YOUR MOUTH HURT WHILE CHEWING? IF SO, WHERE? _____
DO YOU CHEW ON ONLY ONE SIDE OF YOUR MOUTH? IF SO, WHY? _____
ANY REACTIONS OR ALLERGIC SYMPTOMS TO DENTAL ANESTHETHETIC? _____
ANY PROBLEMS WITH PROLONGED BLEEDING IN THE PAST? YES / NO
DO YOUR GUMS BLEED? YES / NO
HAVE YOU BEEN TOLD YOU HAVE GUM DISEASE (PERIODONTITIS)? YES / NO
DO YOU CLENCH OR GRIND YOUR TEETH? YES / NO NIGHT OR DAY _____
ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? YES / NO IF NO, WHY?_____
DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT? YES / NO
HAVE YOU EVER HAD A BAD EXPERIENCE IN A DENTAL OFFICE? IF SO, WHAT?_____
HOW OFTEN DO YOU BRUSH YOUR TEETH? _____ FLOSS? _____

SIGNATURE_____ **DATE**_____
DOCTOR SIGNATURE_____

Medical History Update

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SIGNATURE____DATE________________

PLEASE REVIEW YOUR REGISTRATION AND HEALTH HISTORY FORM AND EXPLAIN ANY CHANGES.

Medical History Update

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