heresi dentalCare
general, cosmetic & implant dentistry

Patient Registration Form

Patient Information

Today's Date: ______________________ E-Mail Address: ______________________

Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ First Name: ______________ Middle Name: ______________ Last Name: ______________

I prefer to be called: ______________________ Male ☐ Female ☐ Birthday: __________ SS#: ______________

Home Address: ______________________ City ______________ State _____ Zip Code __________

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Home #: ( ) ______________ Cell #: ( ) ______________ Work#: ( ) ______________ Ext: __________

Would you like to receive appointment reminders by text message? Standard text message rates apply. Yes ☐ No ☐

Employer Name: ______________ Employer's Address: ______________________ How long there? _______

Occupation: ______________ When is best time to reach you and at what number? ______________________

Whom may we Thank for referring you? ______________ Other family members seen by us: ______________

Previous / Present Dentist: (Please Circle) ______________ Last Visit Date: ______________________

Spouse Information

His / Her Name: ______________________ Employer: ______________________

Wk #: ( ) ______________________ Ext: __________ SS #: ______________________

Birthday: ______________________

Person Responsible for Account: ______________________

Wk #: ( ) ______________________ Ext: __________ Home #: ______________________

Billing Address: ______________________ Relationship: ______________

SS #: ______________________ Employer: ______________________

Insurance

Dental Coverage? Yes ☐ No ☐ Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone #: ( ) ______________ Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________________ Relation: ______________

Insured's Birth date: ______________ Insured's SS #: ______________ Insured's Employer: ______________

Employer's Address: ______________________

Secondary Insurance

Dental Coverage? Yes ☐ No ☐ Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone #: ( ) ______________ Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: ______________ Insured's Birthday: ______________

Insured's SS #: ______________ Insured's Employer: ______________________

Employer's Address: ______________________

Medical History

Do you have a personal physician? Yes ☐ No ☐ Physician's Name: _________________Phone #: (   ) _____________________
Date of last visit: _____________________ Are you currently under the care of a physician? Yes ☐ No ☐
Please explain: ____

Your current physical health is: Good ☐ Fair ☐ Poor ☐ Do you smoke or use tobacco in any other form? Yes ☐ No ☐
Have you had any metal rods, pins or implants? Yes ☐ No ☐
Are you taking any prescription / over-the-counter or herbal supplemental drugs? Yes ☐ No ☐
Please list each one: ____
Have you ever taken Fosamax, or any other bisphosphonate? Yes ☐ No ☐ _____________________________________
Have you ever taken Phen-Fen? Yes ☐ No ☐ If yes, explain ____

For Women: Are you using a prescribed method of birth control? Yes ☐ No ☐
Are you pregnant? Yes ☐ No ☐ Week #: ______________Are you nursing? Yes ☐ No ☐

Have you ever had any of the following diseases or medical problems

Y	**N**	Abnormal Bleeding	**Y**	**N**	Herpes / Fever Blisters
Y	**N**	Alcohol / Drug Abuse	**Y**	**N**	High Blood Pressure
Y	**N**	Anemia	**Y**	**N**	HIV+ / AIDS
Y	**N**	Arthritis	**Y**	**N**	Hospitalized for Any Reason
Y	**N**	Artificial Bones / Joints / Valves	**Y**	**N**	Kidney Problems
Y	**N**	Asthma	**Y**	**N**	Liver Disease
Y	**N**	Blood Transfusion	**Y**	**N**	Low Blood Pressure
Y	**N**	Cancer /Chemotherapy	**Y**	**N**	Lupus
Y	**N**	Colitis	**Y**	**N**	Mitral Valve Prolapse
Y	**N**	Congenital Heart Defect	**Y**	**N**	Osteoporosis / Paget's Disease
Y	**N**	Diabetes	**Y**	**N**	Pacemaker
Y	**N**	Difficulty Breathing	**Y**	**N**	Psychiatric Problems
Y	**N**	Emphysema	**Y**	**N**	Radiation Treatment
Y	**N**	Epilepsy	**Y**	**N**	Rheumatic / Scarlet Fever
Y	**N**	Fainting Spells	**Y**	**N**	Seizures
Y	**N**	Frequent Headaches	**Y**	**N**	Shingles
Y	**N**	Glaucoma	**Y**	**N**	Sickle Cell Disease / Traits
Y	**N**	Hay Fever	**Y**	**N**	Sinus Problems
Y	**N**	Heart Attack	**Y**	**N**	Stroke
Y	**N**	Heart Murmur	**Y**	**N**	Thyroid Problems
Y	**N**	Heart Surgery	**Y**	**N**	Tuberculosis (TB)
Y	**N**	Hemophilia	**Y**	**N**	Ulcers
Y	**N**	Hepatitis	**Y**	**N**	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

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Are you allergic to any of the following?

Y	**N**	Aspirin
Y	**N**	Codeine
Y	**N**	Dental Anesthetics
Y	**N**	Erythromycin
Y	**N**	Latex
Y	**N**	Tetracycline
Y	**N**	Penicillin
Y	**N**	Other

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Dental History

Why have you come to the dentist today? ____
Do you require antibiotics before dental treatment? Yes ☐ No ☐ Are you currently in pain? Yes ☐ No ☐
Have you ever had a serious/ difficult problem associated with any previous dental work? Yes ☐ No ☐
Have you ever had gum treatment? Yes ☐ No ☐
Do you now or have you ever experienced pain /discomfort in your jaw joint (TMJ / TMD)? Yes ☐ No ☐
Your current dental health is Good ☐ Fair ☐ Poor ☐ Do you like your smile? Yes ☐ No ☐
Do your gums ever bleed? Yes ☐ No ☐ How many times a week do you floss? ____ How many times a day do you brush? ____
Type of bristles? Soft ☐ Medium ☐ Hard ☐ How long do you use a toothbrush before replacing it? ____________________
Are your teeth sensitive to heat, cold, or anything else? __________________Have you lost any teeth? Yes ☐ No ☐
If yes, why? ____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature ____ Date ______________________________________

For Office Use Only

I verbally reviewed the medical / dental information above with the patient named herein.

Doctors signature Date

Medical History Update

Have you had any medical changes since your last visit? Yes ☐ No ☐ ____________________________________ Date________ Initials ______
Have you had any medical changes since your last visit? Yes ☐ No ☐ ____________________________________ Date________ Initials ______
Have you had any medical changes since your last visit? Yes ☐ No ☐ ____________________________________ Date________ Initials ______
Have you had any medical changes since your last visit? Yes ☐ No ☐ ____________________________________ Date________ Initials ______