Adult Registration & Health Questionnaire

Tri-Cities Center for Cosmetic Dentistry
KATHY S. SANDERS, DMD, AAACD

Welcome to our practice…
Thank you for selecting us. Please fill out this form in ink.
If you have any questions, or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

Name________________________ ☐Male ☐Female Date________________

Social Security #________________ Birthdate________________ Home Phone________________

Address________________________ City________________ State________ Zip________________

Mobile Phone________________________ Email Address________________________________

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

If Student, Name of School/College________________________ City________________ State______ ☐Full Time ☐Part Time

Patient's Employer ________________________________ Work Phone ________________

Business Address________________________ City ________________ State________ Zip________________

Spouse or Parent's Name________________________ Employer ________________ Work Phone________________

Person to contact in case of emergency ________________________ Phone________________

Emergency contact's relationship to patient________________________________

Whom may we thank for referring you?________________________________

INSURANCE INFORMATION

Answer all questions for the person who holds the insurance policy

Name of Insured________________________ Relationship to Patient ________________

Birthdate________________ SSN#________________ Employee ID________________

Name of Employer________________________________ Work Phone ________________

Employer Address________________________ City ________________ State________ Zip________________

Insurance Company ________________________ Group #________________ Policy/ID#________________

Insurance Company Address________________________ City ________________ State________ Zip________________

~Over Please~

Patient Medical History

Who is your present physician?____

Office Location____________________ Phone______________ Date of Last Exam__________

Do you have or have you had any of the following?

Condition	Yes	No	Don't Know
Active Tuberculosis	☐	☐	☐
Persistant Cough (more than 3 week duration)	☐	☐	☐
Cough that produces blood	☐	☐	☐
Scarlet Fever	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Heart Disease	☐	☐	☐
Prosthetic Joint	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Heart Murmur	☐	☐	☐
Anemia	☐	☐	☐
Asthma	☐	☐	☐
Epilepsy	☐	☐	☐

Condition	Yes	No	Don't Know
Mouth Ulcers	☐	☐	☐
Fever Blisters	☐	☐	☐
Migraine Headaches	☐	☐	☐
Diabetes	☐	☐	☐
Cancer	☐	☐	☐
Radiation Therapy	☐	☐	☐
Chemotherapy	☐	☐	☐
Dry Mouth	☐	☐	☐
Sjögren's Syndrome	☐	☐	☐
Blood or Plasma Transfusion	☐	☐	☐
High Blood Pressure	☐	☐	☐
Low Blood Pressure	☐	☐	☐

Condition	Yes	No	Don't Know
AIDS or HIV+	☐	☐	☐
Lupus	☐	☐	☐
Stroke	☐	☐	☐
Hepatitis, Jaundice, or Liver Disease	☐	☐	☐
Heartburn, Ulcer, Sour Stomach, GERD	☐	☐	☐
Kidney Disease	☐	☐	☐
Thyroid Disease	☐	☐	☐
Bleeding Tendency	☐	☐	☐
Arthritis	☐	☐	☐

Any other disease or condition (please list):
____

	Yes	No
Are you under medical treatment now?	☐	☐

If yes, what conditions are being treated?________________
____

	Yes	No
Have you been hospitalized for any surgical operation or serious illness within the past 5 years?	☐	☐

If yes, please explain ________________________
____

	Yes	No
Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medication(s) are you taking? (please list):
____
____
____

	Yes	No
Are you taking, or have you taken, any diet drugs (e.g. Pondimin, Redux, Phen-fen, or Ephedra)?	☐	☐
Do you have a family history of arthritis?	☐	☐
Do you use a tobacco product?	☐	☐
Recreational drug user?	☐	☐
Have you underwent treatment for drug dependency?	☐	☐

Are you allergic to or have you had any reactions to the following:

	Yes	No
Local Anesthetics (novocaine, etc.)	☐	☐
Penicillin or any other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Codeine or other narcotics	☐	☐
Aspirin	☐	☐
Any metals (nickel, mercury, etc.)	☐	☐
Latex (rubber products)	☐	☐

Other ________________________________
To yes responses, please specify type of reaction________________
____
____

FOR WOMEN ONLY:

	Yes	No
Are you pregnant or think you may be?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

Dental Questions / History

What concerns you most about your teeth / smile?________________________
Are you completely happy with the appearance of your teeth?________________________
Do you have discomfort in any part of the mouth or in any tooth while biting or chewing? ________________
Do you have any pain in your teeth because of heat, cold, or sweets? ________________
Does food catch between your teeth? If so, where?________________________
Do your gums ever bleed or feel tender and swollen? ________________________
Have you ever been informed about having periodontal disease?________________________
How often do you have hygiene visits? ________________________
We currently have treatments for halitosis / bad breath. Is this something you might be interested in?________________
Do you ever have pain from the jaw joint or jaw muscles?________________________
Do you clench or grind your teeth during the day or night?________________________
Does your jaw joint ever pop or click?________________________
Do you have frequent headaches, earaches, or neck pains? ________________________

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such health care to third party payors and/or health practitioners.

*Signature of Patient (or parent if minor)*________________________ *Date*______________