CAPSTONE DENTAL PATIENT REGISTRATION

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: ____ Date: ___________
Last Name First Name Middle Initial

Address: ____ Birthday: ____/____/_____
City State Zip Code

Home: (____)_______________ Cell: (____)_______________ Email: ______________________

Gender: ❒Male ❒Female SS#: ______-______-_________ ❒Married ❒Widowed ❒Single ❒Minor ❒Divorced

In case of emergency who should be notified?: ______________________________ Phone: (____)_____________

Whom may we thank for referring you? ____________________________________

DENTAL INFORMATION

Former Dentist: ____________________________ Phone: ____________________ Last Exam: ___________

Please **(X)** *all areas of concern:*

❒Bad Breath ❒Grinding Teeth ❒Pressure Sensitivity ❒Hot / Cold Sensitivity ❒Sensitivity to sweets
❒Bleeding Gums ❒Clicking / Popping Jaw ❒Loose / Broken teeth ❒Earaches / Neck Pains ❒Periodontal Treatment
❒Mouth Sores / Growths ❒Dry Mouth ❒Denture /Partial discomfort ❒ Food / Floss catch between teeth

How often do you Floss? _____________ How often do you Brush? ___________ Use an electric toothbrush? ❒Yes ❒No

Currently experiencing dental pain / discomfort? ❒Yes ❒No How do you feel about your smile? ___________________________

MEDICAL INFORMATION:

Physician: ________________________________ Phone: ____________________ Last Physical: ___________

Have you had any serious illnesses / operations? ❒Yes ❒No *If yes, describe* ___________________________ Date: _________
___________________________ Date: _________

Have you ever had a blood transfusion? ❒Yes ❒No *If yes,* Date: ___________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand name of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ❒Yes ❒No

Are you currently taking any prescription(s) or over the counter medicine(s)? ❒Yes ❒No *If yes, please list:* _______________________
____
____.

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ❒Yes ❒No *If yes,* Date: ___________

ALLERGIES: *Please (X) if you are allergic to or have had a reaction to:*

❒Local anesthetics ❒Aspirin ❒Penicillin / antibiotics ❒Barbiturates/ Sedatives ❒Codeine / Narcotics
❒Latex (rubber) ❒Metals / Iodine ❒Hay fever / seasonal ❒Animals / Food ❒Other: ___________________.

WOMEN: *Are you pregnant? ❒Yes ❒No Estimated Due Date: __________ Nursing? ❒Yes ❒No On Birth control? ❒Yes ❒No*

Please **(X)** *if you have or have had any of the following:*

❒Anemia ❒Arthritis, Rheumatism ❒Artificial Joint/ Heart Valve ❒Asthma ❒Back Problems
❒Blood Disease/Hemophilia ❒Cancer / Chemotherapy ❒Chemical Dependency ❒Circulatory Problems ❒Cortisone Treatments
❒Cough / Cough w/ Blood ❒Diabetes ❒Epilepsy ❒Fainting ❒Glaucoma
❒Headaches / Migraines ❒Heart Murmur / Disease ❒Hepatitis ❒High/Low Blood Pressure ❒HIV / AIDS
❒Kidney / Liver Disease ❒Mitral Valve Prolapse ❒Pacemaker ❒Radiation Treatments ❒Respiratory Disease
❒Rheumatic / Scarlet Fever ❒Shortness of Breath ❒Stroke ❒Swelling of Feet / Ankles ❒Thyroid Problems
❒Tobacco Habit ❒Tonsillitis ❒Tuberculosis ❒Ulcer ❒Venereal Disease
❒Other: _____________ ❒Other: _____________ ❒Other: _____________ ❒Other: _____________ ❒Other: _____________

AUTHORIZATION:

I certify that the information above is accurate and truthful health history. I will not hold my dentist or other members of Capstone responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I understand and agree that payment is due in full at the time of service. I understand that I am financially responsible for all charges whether or not paid by insurance.

______________________________ ______________________________ ____________________
Signature: Print: Date: