HOOD DENTAL CARE

Patient Registration

Patient Information

First Name ____________________ Middle Initial_______ Last Name________________________ Date___________

Date of Birth __________________Age_____ E-mail address ____

Home Phone _____________________ Cell Phone _________________________Work Phone____________________

Social Security # ______________________________ Driver's License ___________________________________

Address ____

City ____ State _____________________ Zip ___________________

Marital Status: ___Single ___Married ___Divorced ___Widowed ___Separated

Employer____

Employer Address ____ Employer Phone # ____________________

Emergency Contact ____________________________ Relationship ___________________ Phone___________________

How did you hear about us?

____Insurance Provider List ____Google/Internet ____www.hooddentalcare.com ____Flyer
____Welcome to the Neighborhood Letter ____Sign in front of office ____AnotherDoctor:
____ T.V. Commercial ____Family/Friend/Whom can we thank for referring you? ___________________

Insurance

Primary Dental Insurance

Subscriber ____________________________________

Relationship to patient _________________________

Date of Birth_________ SS# _____________________

Employer ____

Work Phone ______________________________________

Insurance Company _______________________________

Ins. Phone #_______________________________________

Group # ____

Secondary Dental Insurance

Subscriber ____________________________________

Relationship to patient _________________________

Date of Birth_________ SS# _____________________

Employer ____

Work Phone ______________________________________

Insurance Company _______________________________

Ins. Phone #_______________________________________

Group # ____

Dental History

What is the reason for your visit today? ____

Date of Last Dental Visit ________________ Last Dental Cleaning________________

Last Full Mouth X-rays ________________ Previous Dentist's Name ___________________________________

Address ____ Telephone ________________________

How often do you brush your teeth? ____________ How often do you floss? ________________

Have you ever used or are currently using topical fluoride? Yes No

Are you extremely fearful of the dentist? Yes No

Are you happy with the appearance of your smile? Yes No

Is there anything about your smile you would like to change? (shape, color, alignment) Yes No

If yes, please explain ____

Dental History cont.

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad Breath	☐Yes	☐No	Fingernail biting	☐Yes	☐No
Bleeding gums	☐Yes	☐No	Food collection between teeth	☐Yes	☐No
Blisters on lips or mouth	☐Yes	☐No	Removable partials or dentures	☐Yes	☐No
Burning sensation on tongue	☐Yes	☐No	Gums swollen or tender	☐Yes	☐No
Chew on one side of mouth	☐Yes	☐No	Jaw pain/grind teeth	☐Yes	☐No
Cheek or lip biting	☐Yes	☐No	Broken fillings or restorations	☐Yes	☐No
Clicking or popping jaw	☐Yes	☐No	Loose teeth	☐Yes	☐No
Dry mouth	☐Yes	☐No	Orthodontic treatment	☐Yes	☐No
Pain around ear	☐Yes	☐No	Periodontal treatment	☐Yes	☐No
Sensitivity to cold	☐Yes	☐No	Sensitivity to heat	☐Yes	☐No
Sensitivity to sweets	☐Yes	☐No	Sensitivity when biting	☐Yes	☐No

Medical History

Have you ever been told to take an antibiotic prior to dental treatment? ☐Yes ☐No
If yes, please list reason: ____
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐Yes ☐No
Date:_______________ If yes, have you had any complications? ______________________

A Are you allergic to or have you had a reaction to:

Local anesthetics	☐Yes	☐No	Aspirin	☐Yes	☐No
Penicillin or other antibiotics	☐Yes	☐No	Metals	☐Yes	☐No
Latex (rubber)	☐Yes	☐No	Iodine	☐Yes	☐No
Sulpha Drugs	☐Yes	☐No	Other ______________________		

Have you ever taken any bisphosphonate medications such as alendronate (Fosamax), risedronate(Actonel), or Boniva for osteoporosis or Paget's disease? ☐Yes ☐No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐Yes ☐No

Are you taking or have you taken blood thinner medications? ☐Yes ☐No

PLEASE LIST ALL pills, medications, or drugs currently taking:
____
____

Are you under a physician's care now? ☐Yes ☐No
If yes: for what reason? ____
When was the last time you saw a medical physician? ______________________________

Have you ever been hospitalized or had a major operation? ☐Yes ☐No
If yes: for what reason? ____

Smoking or tobacco use? ☐Yes ☐No

Have you lost or gained more than 10 pounds in the last year?.......................................☐Yes ☐No
Do you use more than 2 pillows to sleep?..☐Yes ☐No
Do you ever wake up from sleep short of breath?..☐Yes ☐No
Have you ever had excessive bleeding requiring special treatment?...............................☐Yes ☐No

Medical History cont.

Women:
Are you pregnant? ☐Yes Due date:______/______ weeks ☐No
Nursing? ☐Yes ☐No Are you currently **trying** to get pregnant? ☐Yes ☐No
Do you use birth control prescriptions? ☐Yes ☐No

CIRCLE any of the following that apply in either PAST or PRESENT: *Notate if past*

AIDS/HIV Positive(Circle)
Alzheimer's Disease
Anemia
Angina (chest pain)
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problems
Bruise Easily
Cancer/Leukemia
Chemotherapy
Cold Sores/Fever Blisters
Congenital Heart Disorders
Convulsions
Cortisone Medication
Diabetes
Drug Addiction
Eating Disorder
Emphysema
Epilepsy/Seizures
Excessive Bleeding
Excessive Thirst
Fainting/Dizzy Spells
Family History Cardiac Disease
Frequent cough
Frequent headaches
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pacemaker
Heart Surgery
Heart Trouble/Disease
Hemophilia
Hepatitis A,B,C (Circle type)
Herpes
High Blood Pressure
High Cholesterol
Hives/Rashes
Hypoglycemia
Irregular Heartbeat
Kidney Trouble
Liver Disease
Lung Disease
Low Blood Pressure
Mitral Valve Prolapse
Osteoporosis
Parathyroid Disease
Psychiatric Care
Radiation Treatments
Recreational Drug Use
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Shortness of Breath
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Treatment
Tuberculosis (TB)
Tumors
Ulcers

Do you have any disease, condition or problem not listed? If so please list: ______________________________
____
____

Authorization

I certify that the above information is accurate to the best of my knowledge, and that I agree to be treated by Dr. Hood, his associates and the Hood Dental Care staff. I further understand that payment is due at the time of service, and should it become necessary, any attorney fees, court costs, and collection fees become my responsibility and will be added to my account.

I certify that I, and/or my dependent(s), have insurance coverage as described about and assign directly to Hood Dental Care, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I have read a copy of this office's privacy practices, made available upon request.

Print Name ____ Date ____/____/____

Signature____