dirk a. newman DDS

WELCOME

Patient Registration and Dental History

Patient Information

Patient Name _____ Date of Birth _____
Social Security # _____ Marital Status _____
Patient Address _____ City, State, Zip _____
Home Phone _____ Work Phone _____
Email address _____ Cell Phone _____
What is the best way to confirm your dental appointments? _____
Emergency Contact Name and Number _____
Patient's employer _____ Present position _____
Spouse's employer _____ Present position _____
Will the fees for our services be offset by dental insurance? Yes / No
Subscriber Name _____ Relationship to patient _____
Subscriber Date of Birth: _____ Name of Dental Ins. _____
Identification Number _____ Group Number _____
Who may we thank for referring you to our office? _____

Dental History

Are you aware of any dental problems at this time? _____
How long has it been since you have been to a dentist? _____
What was done then? _____
Previous Dentist's name _____ Address _____
Have you ever been told to take antibiotics prior to your dental appointment? Yes/No _____
Have you had any problems or complications with previous dental treatment?
_____

Have you ever had any of the following dental procedures done? If so, please explain.

Gum Treatments or Periodontal Surgery? Yes/No _____
Orthodontic Treatment Yes/No _____
Oral Surgery Yes/No _____
Endodontic Treatment Yes/No _____
Dental Implants Placed Yes/No _____
Have you ever whitened your teeth? Yes/No Are you interested in whitening? _____
Have you lost any teeth or have any teeth been removed? Yes/No Why? _____

Do you experience any of the following:

❑Yes ❑No	Hot/Cold Sensitivity	❑Yes ❑No	Clench or grind your teeth
❑Yes ❑No	Unpleasant Breath	❑Yes ❑No	Difficulty opening or closing
❑Yes ❑No	Bleeding or Tender Gums	❑Yes ❑No	Jaw clicks, pops, or locks
❑Yes ❑No	Food gets caught easily	❑Yes ❑No	Frequently get cavities
❑Yes ❑No	Frequently get cavities	❑Yes ❑No	Build up a lot of plaque/calculus

How often do you brush? _____ How often do you floss? _____
What other products/rinses do you use? _____
Do you usually have teeth numbed for dental work? Yes/No
Do you snack or drink liquids (other than water) in between meals? Yes/No How frequently? _____
If you could change anything about your teeth or smile what would that be? _____
Are you planning to keep your remaining teeth your whole lifetime? Yes/No _____
Is there anything we can do to make your dental appointment more comfortable? _____

I certify that the above information is complete and accurate.

Patient/Guardian Signature _____ Date: _____
Dentist's Initials _____ Date: _____

Complete Reverse Side

Medical History

Patient Name _____

WELCOME, *Please take the time to complete this form with your current medical information. You, and your families medical history will influence your susceptibility to certain dental conditions. The following information should be as complete and accurate as possible as we use it to select the most appropriate dental care for you. Please inform us of any changes to your medical history in the future.*

Physician's Name _____ Physician's Address _____

Date of your last medical physical:_____ Are you currently under the care of a physician? Y / N

Why?_____

Do you or have you had any of the following conditions:

- ❑Yes ❑No Abnormal Bleeding
- ❑Yes ❑No Anemia/Blood disorders
- ❑Yes ❑No Any heart problems
- ❑Yes ❑No Arthritis/Rheumatism
- ❑Yes ❑No Artificial Heart Valve Implant
- ❑Yes ❑No Asthma/Hay fever
- ❑Yes ❑No Blood Pressure Problems: High / Low
- ❑Yes ❑No Cancer, Type:
- ❑Yes ❑No Difficulty Breathing
- ❑Yes ❑No Epilepsy or Seizures
- ❑Yes ❑No Fainting or Dizzy Spells
- ❑Yes ❑No Frequent Headaches, shoulder or neck aches
- ❑Yes ❑No Glaucoma or light sensitivity
- ❑Yes ❑No Heart murmur
- ❑Yes ❑No Diabetes: Type 1 or Type 2

  *Date Diagnosed*_____ *Controlled or Uncontrolled? By Medication or Diet?*
- ❑Yes ❑No Hepatitis, Type:
- ❑Yes ❑No Herpes/Cold Sores/Shingles
- ❑Yes ❑No Kidney/Liver Problems
- ❑Yes ❑No Mental/Emotional Disorders
- ❑Yes ❑No Nervous Problems
- ❑Yes ❑No Organ Transplant, Type:
- ❑Yes ❑No Osteoporosis
- ❑Yes ❑No Prosthetic Joint Replacement Date:
- ❑Yes ❑No Radiation or Chemotherapy Why:
- ❑Yes ❑No Rheumatic Fever
- ❑Yes ❑No Sinus Problems
- ❑Yes ❑No Stomach Problems
- ❑Yes ❑No Stroke
- ❑Yes ❑No Tested Positive for HIV
- ❑Yes ❑No Thyroid: Hypothyroid/Hyperthyroid

Have you ever taken Bisphosphonates such as Actonel, Boniva, Didronel, or Fosamax? Y /N If yes, what:_____

Have you ever taken any prescription weight loss products? Y / N If yes, what:_____

Have you ever had a serious illness or major surgery not listed above? Y / N *If yes, please explain:* _____

_____

Is there a family history of Diabetes, Heart Disease, Oral Cancer, or Periodontal Disease? Y / N *If yes, please explain:*

_____

Would you describe your stress level as high, average, or low? *Circle one.*

Do you smoke, chew, use snuff, or any other forms of tobacco? Y / N *Circle those that apply.*

How long have you used tobacco? _____ *How much do you use?* _____

Have you ever quit or thought about quitting? _____ *Are you interested in quitting?* _____

Please list any medications you are currently taking,
Include prescription and non-prescription:

List any health related substances you take routinely.
Include any vitamins, supplements, or natural products.

Yes / No	List All Allergies
☐ ☐	Latex
☐ ☐	Penicillin
☐ ☐	Sulfa
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Jewelry or metals

Other:_____

If female, please answer the following:

Are you taking Birth Control Pills? Y/ N

Are you pregnant? Y / N If Yes, # of weeks_____

Are you nursing? Y / N

I certify that the above information is complete and accurate.

Patient/Guardian Signature_____ Date:_____

Dentist's Initials_____ Date:_____