ALLEN & NEUMANN
FAMILY DENTISTRY

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 _____
Emergency Contact Name and Number _____
What is the best way to confirm your dental appointments? _____
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 DOB: _____ 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 had any problems or complications with previous dental treatment? Yes/No _____
_____

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

Periodontal Surgery or Scaling and Root Planing? Yes/No _____
Orthodontic Treatment Yes/No _____
Oral Surgery Yes/No _____
Endodontic Treatment 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 Unpleasant Breath
❑Yes ❑No Bleeding or Tender Gums
❑Yes ❑No Food gets caught easily
❑Yes ❑No Frequently get cavities
❑Yes ❑No Clench or grind your teeth
❑Yes ❑No Difficulty opening or closing
❑Yes ❑No Jaw clicks, pops, or locks
❑Yes ❑No Pain or soreness in your face or by your ear
❑Yes ❑No Build up a lot of plaque/calculus
❑Yes ❑No Eat or drink frequently between meals

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
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 _____

Date of Birth _____

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 _____ Clinic Name, Location _____

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

Please check any of the following conditions that you have or have had in the past:

❑Yes ❑No Acid Reflux, or GERD
❑Yes ❑No Alzheimer's or Dementia
❑Yes ❑No Anemia, Blood Disorders, Abnormal Bleeding
❑Yes ❑No Arthritis, Rheumatism, or Gout
❑Yes ❑No Artificial Heart Valve, Implant, or Pacemaker
❑Yes ❑No Asthma
❑Yes ❑No Autoimmune Disease, Type:
❑Yes ❑No Blood Pressure Problems: High / Low
❑Yes ❑No Cancer, Type:
❑Yes ❑No Cold Sores or Canker Sores
❑Yes ❑No COPD, Emphysema, or Difficulty Breathing
❑Yes ❑No Cystic Fibrosis
❑Yes ❑No Diabetes: Type 1 or Type 2
❑Yes ❑No Epilepsy or Seizures
❑Yes ❑No Fainting or Dizzy Spells
❑Yes ❑No Fibromyalgia
❑Yes ❑No Frequent Headaches, Shoulder or Neck Aches
❑Yes ❑No Glaucoma or Light Sensitivity
❑Yes ❑No Hay Fever or Sinus Problems
❑Yes ❑No Heart Attack or Heart Problems
❑Yes ❑No Heart Murmur
❑Yes ❑No Hepatitis, Type:
❑Yes ❑No Kidney/Liver Disease or Problems
❑Yes ❑No Mental/Emotional Disorders
❑Yes ❑No Mitral Valve Prolapse
❑Yes ❑No Nervous System Disease/Problems
❑Yes ❑No Organ Transplant, Type:
❑Yes ❑No Osteoporosis or Osteopenia
❑Yes ❑No Prosthetic Joint Replacement Date:
❑Yes ❑No Radiation or Chemotherapy Why:
❑Yes ❑No Sleep Apnea
❑Yes ❑No STD's: HPV, Venereal Disease, Other
❑Yes ❑No Stroke
❑Yes ❑No Tested Positive for HIV
❑Yes ❑No Thyroid: Hypothyroid/Hyperthyroid
❑Yes ❑No Tuberculosis

Do you have other health conditions or had major surgery not listed above? Y / N *If yes, explain:* _____

_____

Have you ever been told to take antibiotics prior to your dental appointment? Yes/No _____
Have you ever taken Bisphosphonates such as Actonel, Boniva, Didronel, or Fosamax? Y / N If yes, what:_____
Have you ever taken prescription weight loss drugs Phen-fen or Redux? Y / N If yes, when:_____
Is there a family history of Diabetes, Heart Disease, Oral Cancer, or Periodontal Disease? *Circle those that apply*
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? _____ *How much?* _____ *Are you interested in quitting?* _____
Do you consume alcoholic beverages? Y / N Do you use recreational drugs? Y / N

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

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

Yes	No	List All Allergies
☐	☐	Latex
☐	☐	Penicillin
☐	☐	Sulfa
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics

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 Signature_____ Date:_____