Boulos Dental Care

Patient Registration

First Name:______________________________ MI:_____ Last Name:______________________________

Date of Birth:______________ Age:___________ Preferred Name:______________________________

Address:______________________________________ City:__________________ Zipcode:___________

Home Phone Number:___________________________ Cell Phone Number:_______________________

Social Security: ______________________________ Email:_______________________________________

Responsible Party Information:_____________________________________ DOB:__________________

Emergency Contact: Name:________________________________ Phone Number:_________________

Dental History

1. When was your last dental visit:____
2. Dentist's Name and Location:____
3. What was done for you at that time?____
4. Are you satisfied with your past dental treatment? Yes No
5. How long since your last thorough dental exam?____
6. How often do you have your teeth cleaned/examined?____
7. When was your last cleaning?________________________________ X-rays Taken?__________________
8. Are you sensitive to: Hot Cold Sweets Pressure Chewing Other__________________________
9. Do you have signs of gum disease, bleeding, odor or aches? When/where?_______________________
10. Do you have any dental fears? Yes No Explain: ____
11. Do you have any pain or noise in your jaw joints: Yes No Where?____________________________
12. Are you aware of any swelling or lumps in your mouth? Yes No
13. If you could change your teeth what changes would you make?_________________________________

    Would you like your teeth: Straighter? Whiter? Tooth colored fillings? Other:

14. What prompted you to seek dental treatment at this time?__________________________________
15. How did you hear about our dental practice?____

Medical History

Name of Physician: ______________________________ Phone Number: ____________________

1. Are you presently being treated for any medical conditions? Yes No

If yes, please explain: ____

2. Are you taking any medications, including vitamins and supplements? Yes No

If yes, please list: ____

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3. Do you have any allergies (ie; Penicillin, latex, local anesthetic, food products)? Yes No

If yes, please list, including reaction: ____

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1. Do you take a premedication for dental treatment? Yes No
2. Are you taking or have you taken bisphosphonates (ie: Fosamax, Boniva, Actonel, etc)? Yes No
3. Have you ever used or do you currently use tobacco products? Yes No - When did you quit?

   __Cigarettes __ Pipe __Chew __Cigars __E-cigs; How much? __________ How often? ________

4. [Women] Are you pregnant? Yes No Are you breastfeeding? Yes No
5. Do you have or have you ever had any of the following (circle all that apply):

AIDS/HIV Positive	Heart Disease	Rheumatic Fever
Anemia	Heart Murmur	Stroke
Arthritis	Hepatitis (Type __)	Tuberculosis
Asthma/Hay Fever	High or Low Blood Pressure	Tumor/Cancer
Blood Transfusion	Jaundice	Ulcers
Chemical Dependency	Joint Implant	Thyroid Disease
Circulatory Problems	Kidney Problems	Dizziness/Vertigo
Congenital Heart Defect	Learning Disability	Sinus Trouble
Diabetes (Type I / Type II)	Mental Health Care	Sleep Apnea
Epilepsy/Seizures	Mitral Valve Prolapse	Other: ____________
Fainting Spells	Osteoporosis	
Gastrointestinal Disease	Radiation/Chemotherapy	

6. Any other health updates, hospitalizations, or surgeries since your last visit? ____________________

All of the information on both sides of this form is correct to the best of my knowledge. I authorize the administration of medications and the performance of any procedures that are necessary for my dental care. I am aware that I am financially responsible for all dental care provided. I understand that any consideration on my behalf from a dental insurance company is between myself, my employer and the insurance company (companies). I further understand and agree that decisions for dental treatment performed are between the Doctor and myself regardless of any dental insurance involvement. If the dental fees are not paid as agreed, the undersigned shall pay all reasonable attorney and collection fees. I also authorize my insurance benefits to be assigned to: Boulos Dental Care.

Patient Signature: ______________________________________ Date: __________