# DEERFIELD VALLEY **Dental Care -** REGISTRATION FORM

Name:_____Date of Birth: ___/___/_____ SSN: ____ - ___ - ____

Home Phone:(_____)_____ Work :(_____)_____ Cell:(_____)_____

Mailing Address:_____ City, State & Zip: _____

E-Mail Address:_____ Preferred Contact Method: _____

Emergency Contact: _____ Relationship to You & Phone #: _____

Preferred Pharmacy: _____

**MEDICAL HISTORY**

Are you now under the care of a physician? _____ Physician's Name: _____

Please explain:_____

Do you take any blood thinner medications? YES ___ NO ___ If yes, type: _____

Are you presently taking, or have you ever taken any of the following bisphosphonate medications? **(Please circle)**

Etidronate *(Didronel)* Tiludronate *(Skelid)* Alendronate *(Fosomax)* Nisedronate *(Actonel)*
Ibandronate *(Boniva)* Pmidronate *(Aredia)* Zoledronate *(Zometa)* Zoledronic Acid *(Reclast)*
RANK Ligand Inhibitos: Denosumab *(Xgeva, Prolia)*

List any other prescription and/or over-the-counter drugs you are taking: _____

_____

Are you allergic to any of the following? **(Please circle)**

*Aspirin Codeine Dental Anesthetics Erythromycin Latex Penicillin Tetracycline Jewelry Metals Seaweed Sulfa*

**Other Allergies? -** Please List: _____

Do you use tobacco? YES ___ NO ____ If YES, frequency _____

Do you have or have you had any of the following? **(Please circle all that apply)**

| | | | | |
|---|---|---|---|---|
| Anemia | Chemotherapy | Fever Blisters/Herpes | HIV/AIDS | Shingles |
| Anxiety with Dental Visits | Cobalt/Radiation Tx | Glaucoma | Kidney Problems | Sinus Problems |
| Arthritis | Congenital Heart Defect | Heart Attack | Liver Problems | Stroke |
| Artificial Joints | Depression | Heart Murmur | Mitral Valve Prolapse | Thyroid Problems |
| Artificial Valves | Diabetes | Hepatitis | Opthalmic Eye Surgery | Tuberculosis |
| Asthma | Difficulty Breathing | Heart Surgery/Pacemaker | Psychiatric Issues | Ulcers |
| Back Problems | Drug/Alcohol Abuse | Hemophilia/Abnormal Bleeding | Rheumatic Fever | OTHER: _____ |
| Cancer | Epilepsy/Convulsions | High/Low Blood Pressure | Severe Headaches | _____ |

Do you have any artificial joints and/or a medical condition that would require antibiotic Pre-Medication? YES ___ NO __

Please Specify: _____

Date of Joint Replacement (approx) : _____ Surgeon's Name: _____

**WOMEN ONLY**: Are you taking Birth Control Pills? YES ___ NO ___

Are you pregnant? YES ___ *(Week #____ )* NO ____ Are you Nursing? YES ___ NO ____

**PLEASE SEE REVERSE SIDE!**

## Dental Information :

Name of Previous Dentist: _____ Date of Last Visit: _____

What was done at that time? _____

Why have you come to the dentist today? _____

Are you currently experiencing dental pain or discomfort? YES ___ NO _____

If YES, please explain: _____

How many times per day do you brush? ___ Do you use a hard, medium, or soft brush? _____

How many times per week do you floss? ____

**For the following questions please circle. Y = YES; N = NO; or S = SOMETIMES**

| | | | |
|---|---|---|---|
| Do your gums bleed when you brush or floss? | Y N S | Do you have earaches or neck pains? | Y N S |
| Are your teeth sensitive to cold, hot , sweets, or pressure? | Y N S | Do you have any jaw clicking, popping, or discomfort ? | Y N S |
| Is your mouth dry? | Y N S | Do you brux or grind your teeth? | Y N S |
| Have you had any periodontal (gum) treatments? | Y N S | Do you have sores or ulcers in your mouth? | Y N S |
| Have you ever had orthodontic treatment? | Y N | Do you wear dentures or partials? | Y N S |
| Have you had any problems with previous dental treatment? | Y N | Have you ever had a serious head or mouth injury? | Y N S |
| Is your home water supply fluoridated? | Y N | Do you like your smile? | Y N S |

## Dental Insurance:

Primary Dental Insurance Company: _____ State: _____

Group #: _____ Identification #: _____

**Policy Holder Information:**

Name: _____

Employer: _____

Date of Birth: _____ Social Security #: _____

**AUTHORIZATION FOR TREATMENT:**

I understand that the information that I have given today is correct to the best of my knowledge.

I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any change in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____Date: _____

**Deerfield Valley Dental Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin , age, disability, or sex.**