Maitland Family Dentistry

2010 FORM

ADULT PATIENT REGISTRATION: All information is completely confidential

Our office is committed to meeting or exceeding the standards of injection control mandated by the OSHA, the CDC and the ADA

What is the reason for your visit today? ____ Date ________________________

Who may we thank for referring you to our office? ____

Patient Name ____ Birth Date ___________________________

SS# ____ Drivers License # ____________________________________

Home Address ____ Zip ___________

Home Number (____) _______________________________ Cell Phone (_____) ____________________________________

E-Mail Address ____ or Web Site _______________________________________

Occupation _____________________________ Employer Name ____________________ Work # (____) _________________

Nearest Relative Not Living with You (in case of emergency) ________________________________ Phone ____________________

What are your concerns? ***Circle as many as applicable :***(Pain Avoidance) (Appearance) (Losing Teeth) (Gum/Periodontal Disease) (Cavities) (Oral Cancer) (Wasting / Exceeding Dental Insurance Limits) (Your General Health) (Routine Checkup) (Cleaning) (Other) ____

HEALTH UPDATE

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO		YES	NO
1. hospitalization for illness or injury within 1 year			22. high cholesterol		
2. allergic reaction to:			23. diabetes		
aspirin, ibuprofen, acetaminophen			24. stomach or duodenal ulcer		
penicillin			25. digestive disorders		
tetracycline			26. arthritis		
codeine			27. glaucoma		
local anesthetic			28. head or neck injuries		
fluoride			29. epilepsy, convulsions (seizures)		
Metals (gold ,stainless steel)			30. neurological problems		
latex			31. viral infections or cold sores		
Other (list)________________________			32. any lumps or swelling in the mouth		
3. heart problems			33. hives, skin rash, hay fever		
4. heart murmur			34. hepatitis (type___)		
5. rheumatic fever			35. HIV/AIDS		
6. scarlet fever			36. tumor / abnormal growth		
7. high blood pressure			37. radiation therapy		
8. low blood pressure			38. chemotherapy		
9. a stroke			39. antidepressant medication		
10. artificial prosthesis (i.e. heart valve or joints)			40. alcohol / drug dependency		
11. anemia or other blood disorder					
12. prolonged bleeding due to slight cut			**ARE YOU:**		
13. emphysema			41. presently being treated for any other illness		
14. tuberculosis			42. aware of a change in your general health		
15. asthma			43. taking medication for osteoporosis/osteopenia		
16. sinus problems			44. often exhausted or fatigued		
17. kidney disease			45. subject to frequent headaches		
18. liver disease			46. a smoker or previously smoked (within 1 year)		
19. jaundice			47. FEMALE-taking birth control pills		
20. thyroid or parathyroid disease			48. FEMALE-pregnant		
21. hormone deficiency/post menopausal			49. MALE-prostate disorders		

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

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List any medications, supplements, and or vitamins you are currently taking:

Drug	Purpose	Drug	Purpose

Patient's Signature ______________________________________ **Date** ____________________ **Dr.** ____________________