**Dental Registration And History**
**(PLEASE PRINT)**

# Hartsdale Dental Care

**18 North Central Avenue**
**Hartsdale, New York 10530**
**Telephone: (914)761-2310**

Date_____ Home Phone (_____)_____ Cell Phone (_____)_____

## PATIENT INFORMATION

Name_____ SS/HIC/Patient ID#_____
Last Name First Name Middle Initial

Sex: M F Age_____ Birthdate_____ E-mail_____

Address_____City_____ State_____ Zip_____

Married Widowed Separated Dependant/Minor Single Divorced Partnered for_____years

Drivers License #_____Person Responsible for Bill_____

Patient's Employer/School_____ Occupation_____

Employer/School Address_____ Employer/School Phone (_____)_____

## GETTING TO KNOW YOU

1. Why did you select our practice? _____
_____

2. Whom may we thank for referring you?
_____

3. Is another member of your family or relative a patient of the practice?_____
_____

4. Person to contact in an emergency:_____
Phone #_____

5. When was your last dental visit_____

6. When was the last time you had complete dental radiographs taken?
_____
Name and address of last dentist?
_____
_____

7. Have you ever had any teeth removed? Yes No
How long have they been missing?_____
Have these teeth been replaced?_____
How? Bridge Partial Denture Implants

Reason for today's visit_____

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I hereby authorize Dr. Andrew Woo to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above. I also authorize Dr. Woo to choose treatment or assistance by an employee of this practice as he sees fit. I understand that previous to treatment a full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

_____
Signature of Responsible Party Relationship to Patient Date

## DENTAL HISTORY

How do you feel about getting and maintaining a healthy mouth?_____
If you could change anything about your smile, what would you change?_____
Do you feel very nervous about dental treatment?..... Yes No
Have you had a bad experience at a dental office?..... Yes No
Are you having any dental problems at this time..... Yes No
If yes, please explain_____
How often do you brush?_____ How often do you floss?_____
Circle if you have any of the following problems:
Bad breath Dry mouth Periodontal treatment Clicking or popping jaw Sensitivity to hot/cold Bleeding gums
Sensitivity to biting Grinding teeth Jaw pain Sores or growths Loose teeth/fillings Food getting trapped

## MEDICAL HISTORY

Physician's Name_____ Date of last physical examination_____

Physicians address_____ Physician's phone(_____)_____

Are you currently under the care of a medical physician in the last two years for any health concern….. Yes No

If yes please state the reason_____

Have you had a blood transfusion? Yes No If yes, give approximate date(s)_____

Have you had any operations? Yes No If yes, when and what for_____

Are you on a special diet? Yes No If yes, please describe_____

Have you gained or lost 10 or more pounds in the last year?..... Yes No

Have you ever used a Bisphosphonate medication? ( Fosamax, Actonel, Atelvia, Didronel, Boniva)..... Yes No

Have you ever taken any of the drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine) Pondimin (fenfluramine) and Redux (dexfenfluramine)?..... Yes No

Please circle if you have or have had ANY of the following:

| | | | |
|---|---|---|---|
| Eating Disorder | Diabetes | Anemia | Seasonal Allergies |
| Emphysema | Headaches | Scarlet Fever | Glaucoma |
| Artificial Heart Valve(s) | Epilepsy | Heart Murmur | Shortness of Breath |
| Psychiatric Treatment | Radiation Treatment | Hemophilia | Skin Rash |
| Artificial Joints | Fainting | Heart Disease | Genital Herpes |
| Back Problems | Hepatitis | Stroke (date_____) | Arthritis |
| Alcoholism | High Blood Pressure | Asthma | Thyroid Disease |
| Cancer | Rheumatic Fever | HIV/AIDS | Tonsillitis |
| Respiratory Disease | Chemotherapy | Kidney Disease | Tuberculosis (date_____) |
| Circulatory Problems | Liver Disease | Ulcer | Cold Sores or Fever Blisters |
| Pacemaker (date_____) | Cortisone Treatments | Mitral Valve Prolapse | Sickle Cell Disease |
| Migraines | Depression | Vertigo | Drug Addiction |
| Recreational Drug Use | Congestive Heart Failure | Low Blood Pressure | |

Do you have any other diseases, conditions or problem not listed?_____

_____

Do any of the above conditions require further explanation?_____

_____

Are you a tobacco user? Yes No If yes, what kind and how frequently?_____

Are you pregnant? Yes No Due date_____ Nursing? Yes No Taking birth control pills? Yes No

## MEDICATIONS

List any medication you are currently taking (OTC or prescription)

_____

_____

_____

Pharmacy Name_____

Phone Number(_____)_____

## ALLERGIES

Please circle:

| | |
|---|---|
| Aspirin | Sulfa |
| Barbiturates | Penicillin |
| Codeine | Latex |
| Local Anesthetic | Other_____ |

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The above information is accurate and complete to the best of my knowledge. I will not hold Dr. Woo or any member of his staff responsible for any omissions or errors that I have made in the completion of this form.

Date_____ Signature_____

Relationship to patient_____ Print Name_____