NORTH ROCKVILLE DENTAL

Thanh Lam DDS FAGD

PATIENT REGISTRATION

Birthdate ____________

Name ______________________________ Mobile phone ____________

Home Address ______________________________

______________________________ Home phone ____________

Work Address ______________________________

______________________________ Work phone ____________

E-mail Address ______________________________

Emergency contact ______________________________ Home phone ____________

Relationship ______________________________ Mobile phone ____________

Work phone ____________

Preferred method of contact E-mail ☐ Mobile # ☐ Home # ☐ Work # ☐

INSURANCE INFORMATION

Insurance Company ______________________________ Group # ____________

Address ______________________________ Policy # ____________

______________________________ Telephone ____________

MEDICAL INFORMATION

Are you currently being treated by a physician? Yes No

Name of Physician ______________________________ Telephone ____________

ALLERGIES

Penicillin, other antibiotics	Yes	No	Metals (Nickel, etc)	Yes	No
Latex	Yes	No	Seasonal	Yes	No
Local Anesthetics	Yes	No	Animals	Yes	No
Sulfa Drugs	Yes	No	Food	Yes	No
Codeine or other narcotics	Yes	No	Medications (specify)	Yes	No

Other ______________________________

MEDICAL CONDITIONS – do you have or have you ever had the following:

Sinus problems	Yes	No	AIDS / HIV	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No
Diabetes	Yes	No	Liver disease	Yes	No
Heart Disease	Yes	No	Kidney disease	Yes	No
Low blood pressure	Yes	No	Abnormal bleeding	Yes	No
High blood pressure	Yes	No	Thyroid problems	Yes	No
Rheumatic fever	Yes	No	Autoimmune disease	Yes	No
Pacemaker	Yes	No	Hives or skin rash	Yes	No
Congenital heart disease	Yes	No	Tuberculosis	Yes	No
Artificial heart valve	Yes	No	Artificial Joint	Yes	No
Infective endocarditis	Yes	No	Cancer	Yes	No
Organ transplant	Yes	No	Gastrointestinal disease	Yes	No
Antibiotic phophylaxis needed	Yes	No	Smoker/Tobacco use	Yes	No

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MEDICATIONS – please list any medications you are currently taking:

____
____
____
____
____
____

Are you pregnant or do you think you may be pregnant? Yes No
Are you taking or have you taken bisphosphonates for osteoporosis or Paget's disease? Yes No

DENTAL INFORMATION

What is the reason for your visit today? ______________________

Sensitive teeth	Yes	No	Grind / clench teeth	Yes	No
Dry mouth	Yes	No	Sores / ulcers	Yes	No
Headaches	Yes	No	Broken teeth	Yes	No
Bleeding gums	Yes	No	Missing teeth	Yes	No

Date of last dental exam ________ Treatment performed? ________________
Date of last dental x-rays ________ Type of x-ray taken? ________________

Do you have any other issues you would like to make us aware of? ________________

____

Who may we thank for referring you? ______________________

I attest that the information I have provided is an accurate and complete representation of my health history. I will not hold my dentist or any of his/her staff responsible for any actions that may result from omissions or inaccuracies.

Signature ______________________ Date ______________

I authorize my dentist and his/her staff to release any of my information that will be necessary to process insurance claims. I also authorize the assignment of benefits provided by my insurance to my dentist for professional services rendered. By declining to sign accept the responsibility of providing payment at the time of service and processing insurance claims.

Signature ______________________ Date ______________