Mark Cooper, D.D.S., PC
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Chester, New York 10918
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Medical History & Registration

(PLEASE FILL OUT THIS FORM IF YOU ARE AT LEAST 18 YEARS OLD)
Name ___________________________ Phone (H) ______________ (W) ______________ (Cell) ______________
Street address _________________________________ City ____________________ State/Zip ______________
Date of birth ________________________ Social Security number ________________________Sex ___________
Marital status: (S) ____ (M) ____ (D) ____ (W) ____ Name of spouse __________________________________
Your relationship to patient (Self) ____ (Parent) ____ If parent, YOUR Social Security # ____________________
Occupation _______________ Employer name/address ____
In case of an emergency, name of relative NOT living with you: ______________________ What is their telephone number ________________________ What is their relationship to you __________________________
How did you hear about our office? _________________________Your email address______________________

Your answers below are for our records and are considered confidential:

****MEDICAL****

Any changes in your health within the past year? Yes _____ No _____
Are you seeing a medical doctor now? Yes _____ No _____
Condition(s) you are being treated for ____
Name of medical doctor _________________________________ City/State_______________________________
____ Last physical (mo/yr) _________________________________
Have you EVER been hospitalized? Yes_____ No _____ If yes, reason _________________________________

CIRCLE any of the following which you have had or presently have:

Heart murmur
Rheumatic fever
Heart trouble
Pacemaker
High blood pressure
Allergies
Asthma
Hives
Cold sores
Fainting spells
Epilepsy
Jaundice
Arthritis
Stomach ulcers
Tuberculosis
Thyroid disease
Venereal disease
Cancer
Blood disorder
Drug addiction
Diabetes

Damaged or artificial heart valves
Mitral valve prolapse
Heart attack
Stroke
Artificial joints
Sinus trouble
Hay fever
Skin rash
Canker sores
Seizures
Hepatitis
Liver disease
Rheumatism
Kidney trouble
Persistent cough
Lung disease
Psychiatric problems
Aids
Transfusions
Alcoholism

Other conditions not listed above ____
Medicine allergies (please list) ____
Medicine you are taking (please list) ____
Are you pregnant _____ nursing _____ (please check)

**** DENTAL ****

How long has it been since your last dental visit? (months/years ago) ___________________________________
If over a year, what is the reason why you avoid regular care? ____
What did you have done at your last dental visit? ____
When was your last full set of dental x-rays taken? (date or years ago) __________________________________
Are you having dental problems now? (describe) ____
____

FOR THE QUESTIONS BELOW CHECK ALL THAT APPLY

Do your gums bleed _____ feel tender _____ feel irritated _____?
Are your teeth sensitive to hot _____ cold _____ sweets _____ pressure _____?
Do you have headaches _____ earaches _____ neck pain _____ jaw clicking _____?
Have you worn braces? Yes _____ No _____
Have you had any abnormal bleeding associated with previous dental work, general surgery or trauma?
Yes _____ No _____
Have you had any surgery, radiation or drug treatment of the head or neck for a growth or tumor?
Yes _____ No _____
Have you had any serious trouble associated with previous dental treatment? If yes, please explain
____
Are you wearing removable dental appliances? Yes _____ No _____
Are you employed in a job which uses radiation? Yes _____ No _____

I certify that I have read and understand the above. Any questions I have about the above inquiries have been answered to my satisfaction. I will notify your office of any changes in the above medical history.

Print name of person filling out this form _______________________________________
Signature (patient or parent) ______________________________ date _______________
Signature (dentist) ____

Changes in medical history: **(for office use)**

Date	no	yes	describe