SUNSHINE FAMILY DENTISTRY

Adult

PATIENT INFORMATION **PLEASE PRINT**

ADULT REGISTRATION

DATE: _____

FULL NAME: _____

HOME PHONE: _____

NICKNAME: _____

WORK PHONE: _____

STREET ADDRESS: _____

CELL PHONE: _____

CITY/STATE/ZIP: _____

EMAIL: _____

GENDER: M / F MARITAL STATUS S M D W

SSN#: _____

WHOM MAY WE THANK FOR YOUR REFERRAL?: _____

DOB: _____

HEALTH INFORMATION

IT IS VERY IMPORTANT THAT WE KNOW ABOUT YOUR DENTAL/MEDICAL HISTORY. MANY THINGS HAVE A DIRECT BEARING ON DENTAL HEALTH/TREATMENT. ALL INFORMATION IS CONFIDENTIAL.

PHYSICIAN'S NAME: _____ PHONE: _____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE Y / N (Please circle one)

REASON(S): _____

CURRENT MEDICATIONS: _____

EVER HOSPITALIZED? Y / N (Please circle one) DATE(S) OF HOSPITALIZATION: _____

REASONS: _____

ANY SPECIAL NEEDS? _____

FINANCIAL RESPONSIBILITY/EMERGENCY INFORMATION

PERSON(S) FINANCIALLY RESPONSIBLE: _____ RELATION: _____

EMERGENCY CONTACT: _____ / TYPE OF RELATION: _____ PHONE: _____

PRIMARY INSURANCE INFORMATION

EMPLOYED BY: _____

WORK PHONE: _____

DENTAL INSURANCE CO: _____

INS. CO. PHONE: _____

NAME OF POLICY HOLDER: _____

POLICY HOLDERS SSN# _____

GROUP NUMBER: _____

POLICY HOLDERS DOB: _____

POLICY ID NUMBER: _____

RELATION TO POLICY HOLDER: _____

SECONDARY INSURANCE INFORMATION

EMPLOYED BY: _____

WORK PHONE: _____

DENTAL INSURANCE CO: _____

INS. CO. PHONE: _____

NAME OF POLICY HOLDER: _____

POLICY HOLDERS SSN# _____

GROUP NUMBER: _____

POLICY HOLDERS DOB: _____

POLICY ID NUMBER: _____

RELATION TO POLICY HOLDER: _____

HEALTH HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CHECK YES OR NO TO EACH.

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

Angina	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Arthritis / Rheumatism	❑ Yes ❑ No	HIV / Aids	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Immune Deficiency	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Bleeding Abnormally,		Autoimmune Disorder	❑ Yes ❑ No	Tumor / Malignancy	❑ Yes ❑ No
with extractions or surgery	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No	Ulcer	❑ Yes ❑ No
Bleeding Problems/Blood Thinners	❑ Yes ❑ No	Joint Replacement : Hip / Knee	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Kidney Disease/Problems	❑ Yes ❑ No		
Chemical Dependency	❑ Yes ❑ No	Liver Problems	❑ Yes ❑ No	**DENTAL HISTORY**	
Chemotherapy	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Bad Breath	❑ Yes ❑ No
Cigarette / Pipe / Cigar / Dip	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No	Bleeding Gums	❑ Yes ❑ No
Circulatory Problems	❑ Yes ❑ No	Nervous Problems	❑ Yes ❑ No	Blisters on Lips or Mouth	❑ Yes ❑ No
Congenital Heart Lesions	❑ Yes ❑ No	Organ Transplant	❑ Yes ❑ No	Broken Fillings	❑ Yes ❑ No
Cortisone Treatments	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No	Clenching of Teeth	❑ Yes ❑ No
Cough, persistent or bloody	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No	Clicking or Popping Jaw	❑ Yes ❑ No
Defibrillator/Pacemaker	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No	Dry Mouth	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Respiratory Problems	❑ Yes ❑ No	Grinding of Teeth	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No	Gums Swollen or Tender	❑ Yes ❑ No
Epilepsy / Seizures	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No	Jaw Pain / Jaw Tiredness	❑ Yes ❑ No
Fainting or Dizziness	❑ Yes ❑ No	Shunt Placed	❑ Yes ❑ No	Lip or Cheek Biting	❑ Yes ❑ No
Glaucoma	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No	Loose Teeth	❑ Yes ❑ No
Headaches (____ x per month)	❑ Yes ❑ No	Special Diet	❑ Yes ❑ No	Mouth Breathing	❑ Yes ❑ No
Heart Attack (year:_____)	❑ Yes ❑ No	Stroke (year:_____)	❑ Yes ❑ No	Sensitivity to Cold / Heat / Sweets	❑ Yes ❑ No
Heart Murmur	❑ Yes ❑ No	Swollen Feet / Ankles / Neck Glands	❑ Yes ❑ No	Sores or Growth in your Mouth	❑ Yes ❑ No
Heart Valve / Replacement Stent	❑ Yes ❑ No	Taking Blood Thinner Medications	❑ Yes ❑ No		
Hepatitis A / B / C	❑ Yes ❑ No	Taking Insulin	❑ Yes ❑ No		
Herpes	❑ Yes ❑ No	Taking Medication for Osteoporosis	❑ Yes ❑ No		

WOMEN:

Are you pregnant?	❑ Yes ❑ No	Due Date _____	Are you nursing? ❑ Yes ❑ No
Taking birth control pills?	❑ Yes ❑ No		

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

❑ Aspirin
❑ Barbituates (Sleeping Pills)
❑ Codeine
❑ Iodine
❑ Latex
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other _____

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

UPDATES (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No
For what condition? _____

Are you taking any new medications? ❑ Yes ❑ No If so, what? _____

_____

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No
For what condition? _____

Are you taking any new medications? ❑ Yes ❑ No If so, what? _____

_____

_____

Signature of Patient, Parent, Guardian or Personal Representative Date