PATIENT REGISTRATION
NuYu Dental

Date_____

Patient Name _____ Birth date_____ Age_____
First Middle Last

DL#_____SS#_____ Occupation _____

Marital Status-circle: Single Married Divorced Widowed Spouses Name: _____

Home Address_____ Zip _____

Home Number (____)_____ Cell Phone (___)_____ Work #(___)_____

E- Mail Address _____

Employer Name and Address _____

Person Responsible for Account_____ Relationship _____Phone#_____

Do you have dental insurance-cirlce: YES NO If yes, with Whom? _____

Emergency Contact_____ _____ Relationship_____

Address_____ Zip_____ Best Phone # (_____)_____

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for you particular needs.

Are you currently having dental problems? _____

_____

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) _____

Please answer each question. Circle yes or no.

1. Are you in good health now? ..... Yes No
2. Are you presently under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
3. Have you ever had high blood pressure?..... Yes No
4. Has a physician ever said you have heart trouble?..... Yes No
5. Have you ever had excessive or abnormal bleeding following a cut or extraction, or do cuts take longer to heal now than before?.. Yes No
6. (Women) Are you pregnant? If so, give due date _____ Yes No
7. Do you use tobacco in any form? If yes, how much? _____ Yes No
8. Do you use alcoholic beverages (more than 2 drinks per day)? _____ Yes No
9. Are you ALLERGIC or have you ever experienced any reaction to the following?
   Local anesthetic (ex/Novocain) ..... Yes No Aspirin or Codeine..... Yes No LATEX..... Yes No
   Barbiturates/sedatives/sleeping pills.... Yes No Sulfa Drugs.....Yes No Penicillin ..... Yes No
   Other Antibiotics Allergies_____
   Other Allergies_____
10. Are you taking any of the following?
    Antibiotics/Sulfa Drugs..... Yes No Tranquilizers.....Yes No Blood thinners..... Yes No
    Insulin/other Diabetes drugs..... Yes No Recreational Drugs..... Yes No Thyroid Medicine.... Yes No
    Blood Pressure medication..... Yes No Cortisone/steroids..... Yes No Nitroglycerin ..... Yes No
    Digitalis/other heart medication..... Yes No Aspirin..... Yes No Cold Remedies..... Yes No
    Antihistamines/allergy/cold medicine... Yes No Other medication_____

If yes to any of the above, list **name** of medication and **dosage** below:

1._____
2. ._____
3. ._____
4. ._____

11. Have you ever had any serious trouble associated with previous dental treatment ..... Yes No
    If so, explain _____
12. Does dental treatment make you nervous? No Slightly Moderately Extremely
13. Date of last dental visit (month/years) _____k
14. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ..... Yes No

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15. Do you have or have you ever had any of the following?

SKIN
Eczema/Hives/Rash ..... Yes No

EYES
Visual Change ..... Yes No
Glaucoma ..... Yes No

EARS
Loss of hearing ..... Yes No
Ringing in ears ..... Yes No

NOSE
Frequent nosebleeds ..... Yes No
Sinus problems ..... Yes No

THROAT
Soreness/hoarseness ..... Yes No

NERVOUS SYSTEM
Stroke ..... Yes No
Headaches ..... Yes No
Convulsions/epilepsy ..... Yes No
Numbness/tingling ..... Yes No
Dizziness/fainting Yes ..... Yes No
Psychiatric treatment ..... Yes No

RESPIRATORY
Tuberculosis ..... Yes No
Emphysema ..... Yes No
Asthma/Hay fever ..... Yes No
Persistent cough ..... Yes No
Sputum production (Phlegm) ..... Yes No
Cough up bloody sputum ..... Yes No
Difficulty breathing lying down ..... Yes No

ENDOCRINE
Diabetes ..... Yes No
Family history of Diabetes ..... Yes No
Thyroid condition/goiter ..... Yes No
Other_____

BONE/MUSCLES
Arthritis/rheumatism ..... Yes No
Artificial joints/implants ..... Yes No

DIGETIVE SYSTEM
Hepatitis ..... Yes No
Jaundice ..... Yes No
Ulcers ..... Yes No
Change in appetite ..... Yes No

HEART/BLOOD VESSELS
Rheumatic Fever ..... Yes No
Heart Murmur ..... Yes No
Chest pain/Discomfort ..... Yes No
Heart attack/trouble ..... Yes No
Shortness of breath ..... Yes No
High blood pressure ..... Yes No
Congenital heart disease ..... Yes No
Artificial heart valve ..... Yes No
Pacemaker ..... Yes No
Heart surgery ..... Yes No
Other_____

URINARY
Kidney disease ..... Yes No
Increase frequency of urination (night) ..... Yes No
Burning on urination ..... Yes No
Urethral discharge ..... Yes No
Bloody urine ..... Yes No
Venereal disease ..... Yes No

BLOOD
Bruise easily ..... Yes No
Anemia or leukemia ..... Yes No
Blood transfusion ..... Yes No

OTHER
Radiation therapy ..... Yes No
Tumors or growths ..... Yes No
Cancer ..... Yes No
Aids ..... Yes No

Any other information you think is important for us to know:
_____

16. Do you have or have you ever had any of the following?

MOUTH
Bleeding, sore gums ..... Yes No
Unpleasant taste/bad breathe ..... Yes No
Burning tongue/lips ..... Yes No
Frequent blister, lips/mouth ..... Yes No
Swelling/lumps in mouth ..... Yes No
Ortho treatments (braces) ..... Yes No
Biting cheeks/lips ..... Yes No
Clicking/popping jaw ..... Yes No
Difficulty opening or closing jaw ..... Yes No

TEETH
Loose teeth ..... Yes No
Sensitive to hot ..... Yes No
Sensitive to cold ..... Yes No
Sensitive to sweets ..... Yes No
Sensitive to biting ..... Yes No
Food impaction ..... Yes No
Clenching/grinding ..... Yes No
Shifting of teeth ..... Yes No
Change in bite ..... Yes No
Headaches or jaw muscle soreness when waking up .. Yes No

ORAL HYGIENE
Do you use the following?
Brush ..... Yes No
Dental floss ..... Yes No
Fluoride rinse ..... Yes No
Other _____
How often do you brush _____
Brush is: soft medium hard

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at my next dental appointment.

X_____

Signature of patient, parent or guardian:

Date_____

Who may we thank for referring you? Please circle
Website/Internet Search: Google Yahoo Yelp
Driving by/Sign
Friend – name?
Doctor referral – name?
Magazine – name?
Mailer – when did you receive it?
Other:

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of_____'s dental needs. (name of patient)
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents entails certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I understand that for a new patient or recall exam, I authorize the doctor to perform a cleaning and I understand the risks associated, but not limited to: bleeding, hot and cold tooth sensitivity, and cleaner teeth :)

X_____

Signature of patient, parent or guardian:

Date_____

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