endicott dental
family and implant dentistry

Registration

Name: Last:__________________ First:__________________ Middle Initial: ________

Gender: M F Birthdate:_________ Age:________

If patient is a minor, give parent or guardian's name: ____

Where did you hear about us?____

Patient/ Responsible Party

Name: Last:_________________ First: ________________ M: _________ Marital Status ______________

Residence Street: ____ City: ______________________

State: _________ Zip: ____________

Mailing Address: ____ City: _____________________

State: _________ Zip: ____________ e-mail address: ________________________________

Home Phone: _________________ Work Phone: __________________ Cell:_____________________

Social Security # __________________ Birthdate: ____________ Driver's License# ________________

Relation to patient: _______________ Employer: __________________ Occupation: _______________

Responsible Party's Spouse

Name : __________________________________

Employer: ________________________________

Occupation: _______________________________

Social Security # __________________________

Phone: ___________________________________

DOB: _____________________________________

Emergency Information

(Relative not living with you)

Name: __________________________________

Address: _______________________________

City: ________________ State: ______________

Phone: __________________________________

Dental Insurance (Primary)

Insured's Name: ___________________________

Insurance Company: _______________________

Insurance Co. Address: _____________________

____

Insured's Employer: _________________________

Insured's Social ______________ Group: _______

Dental Insurance (Secondary)

Insured's Name: ___________________________

Insurance Company: ______________________

Insurance Co. Address: ____________________

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Insured's Employer: _______________________

Insured's Social: ___________ Group: ________

Patient Signature (Responsible Party for Child) _______________________________ **Date:** ______________

Patient Medical and Dental History

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Please complete the following to the best of your ability.

When did you last see a dentist?	
Date of last COMPLETE dental exam	
Date of last x-rays	
Are you having any problems now?	
If yes, please explain:	
Do you were dentures or partials?	
Would you like to know more about implants?	
Are you apprehensive about dental treatment?	
Have you had periodontal (gum) treatments?	
Do your gums bleed or feel tender or irritated?	
Are your teeth sensitive to hot or cold?	
Are you unhappy with the appearance of your teeth?	
Are you aware of grinding or clenching of your teeth?	
Do you have headaches, earaches, or neck pain?	
Have you worn braces or done orthodontics?	
Do you have discolored teeth that bother you?	
Do you regularly use dental floss?	
Do you have any jaw or joint pain?	
Do you smoke or use any tobacco product?	
Do you have frequent mouth sores/ lesions?	
Do you snore?	
Name of previous dentist	
Anything else you'd like us to know?	

Check any past or current condition.

Heart disease		Hemophilia	
Angina Pectoris		Fever Blisters	
High Blood Pressure		Epilepsy or Seizures	
Heart Murmur		Depression/ Anxiety	
Rheumatic Fever		Psychiatric Treatment	
Congenital Heart Lesion		Glaucoma	
Mitral Valve Prolapse		Chemotherapy	
Artificial Heart Valve		Venereal Disease	
Pacemaker		Bruise Easily	
Heart Surgery		Emphysema	
Artificial Joints		Tuberculosis	
Anemia		Asthma	
Stroke		Hay Fever	
Kidney Trouble		Sinus Trouble	
Ulcers		Allergies or Hives	
AIDS/ HIV		Diabetes/ Type: _____	
Hepatitis A		Thyroid Disease	
Hepatitis B		Radiation Treatment	
Hepatitis C		Arthritis	
Blood Transfusion		Cortisone Medicine	
Drug Addiction		Pain in Jaw Joints	
Cosmetic Surgery		Alcoholism	
Osteoporosis/osteopenia		Organ transplant	
Impaired eyesight/ Glaucoma		Hearing aid/ Hearing disorder	
Autoimmune disorder		Parkinson's Disease	
Cancer If yes, please list type.		Liver Disease	
		Artificial joints	

Medical History Continued

Please fill out the following to the best of your ability.

Physician's Name: ______________________ City/State: ___________________________Phone: ________________

Date of most recent visit to your physician:_______________

Are you pregnant? ___________ Due date:______________ Are you currently nursing? _____________

Are you currently being treated for any ongoing medical issue?________ If so, what condition?___________________

When was your last physical exam with blood testing? __________

Have you been hospitalized or had a serious illness within the last year? __________

If yes, please explain: ____

Have you ever been advised to take antibiotics before a dental appointment: __________

If yes, please explain: ____

Have you had any serious medical trouble associate with any dental experience? ___________

If yes, please explain: ____

Are you allergic to or have you reacted adversely to any of the following medications?

Asprin Local Anesthetic Erythromycin Nitrous Oxide Codeine Penicillin

Are you allergic to any other medications or substances? __________ If yes, what? _____________________________

Please list ALL medications, herbal medications, and vitamins/supplements you currently take.

Name of medication: Dosage: Condition/ Reason you are taking:

____

____

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____

____

____

____

Patient Signature: ____ Date:_________________________

(parent or guardian, if minor)