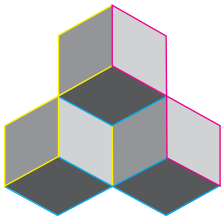

WYNDHAMSMITH&KIMDENTISTRY

REGISTRATION HISTORY

PATIENT INFORMATION: Date: _____

Patient's Name: _____ Circle: Mr. / Mrs. / Ms.

Social Security /ID Number: _____ Birth date: _____/_____/_____

Guardian's Name (if patient is under 18 yrs. of age) _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Employer's Name: _____ Phone: _____

City, State, Zip: _____

Present position? _____ How long? _____

E-mail: _____ ☐ I would like to receive correspondences via-email

Text Contact #: _____

Emergency Contact: _____ Phone Number: _____

MAIN SUBSCRIBER INFORMATION:

Same as Above? Yes _____ (if No please fill in information below)

Name of Subscriber: _____ Relationship to Patient: _____

Social Security/ID Number: _____ Birth date: _____/_____/_____

Employer's Name: _____ Phone: _____

City, State, Zip: _____

Present position? _____ How long? _____

DENTAL INSURANCE INFORMATION:

Insurance Name: _____ Group #: _____ I.D #: _____

Insurance Phone Number: _____

Whom may we thank for referring you to us? _____

Comments: _____

DENTAL AND MEDICAL HISTORY -UPDATES

DENTAL INFORMATION:

CIRCLE:

Do you have a specific dental problem ? _____ YES / NO
Do you have dental examinations on routine basis ? Last visit: _____ YES / NO
Do you think you have active decay or gum disease ? _____ YES / NO
Do you brush and floss on a routine basis ? _____ YES / NO
Do your gums ever bleed ? _____ YES / NO
Do you have discomfort in the jaw joint ? _____ YES / NO
Have past experiences in dental offices always been positive ? _____ YES / NO
Do you smoke or chew tobacco ? _____ YES / NO

MEDICAL HISTORY:

Are you under a physicians care? Why? _____ YES / NO
Name of physician and Phone Number: _____
Have you ever had a major operation? Discuss: _____ YES / NO
Have you had a serious injury to the head/neck? Discuss: _____ YES / NO
Are you taking any medication/pills/drugs? Explain: _____ YES / NO
Are you taking or have taken Fosamax or Actonel?: _____ YES / NO
Have you ever taken Phen Phen? Discuss: _____ YES / NO
Are you allergic to any medications or substances? _____ YES / NO

Aspirin ( ) Penicillin ( ) Codeine ( ) Acrylic ( ) Metal ( ) Latex Rubber ( ) Other ( ) _____

WOMEN (Please check): Pregnant or think you might be ( ) Nursing ( )

Do you have or have you had any of the following? Check the appropriate lines:

PRE-MEDICATIONS MAY BE REQUIRED

YES/NO		YES/NO		YES/NO		YES/NO	
___ ___	HEART/DISEASE	___ ___	SICKLE CELL DISEASE	___ ___	ULCERS	___ ___	AIDS
___ ___	HEART MURMUR	___ ___	HEMOPHILIA	___ ___	RECENT WEIGHT LOSS	___ ___	HIV POSITIVE
___ ___	IRREGULAR HEART BEAT	___ ___	LEUKEMIA	___ ___	DIABETES	___ ___	GENITAL HERPES
___ ___	ANGINA/CHEST PAIN	___ ___	BLOOD TRANSFUSION	___ ___	EXCESSIVE THIRST	___ ___	HIVES OR RASH
___ ___	HEART ATTACK/FAILURE	___ ___	SWELLING OF LIMBS	___ ___	HYPGLYCEMIA	___ ___	COLD SORES
___ ___	HEART DISORDER	___ ___	BREATHING PROBLEMS	___ ___	LIVER DISEASE	___ ___	FEVER BLISTERS
___ ___	MITRAL VALVE PROLAPSE	___ ___	SHORTNESS OF BREATH	___ ___	DRUG ADDICTION	___ ___	HERPES
___ ___	SCARLET FEVER	___ ___	FREQUENT COUGH	___ ___	ALLERGIES	___ ___	STROKE
___ ___	ARTIFICIAL HEART VALVE	___ ___	HAY FEVER	___ ___	YELLOW JAUNDICE	___ ___	CONVULSIONS
___ ___	PACE MAKER	___ ___	SINUS TROUBLE	___ ___	KIDNEY PROBLEMS	___ ___	EPILEPSY/SEIZURES
___ ___	HEART SURGERY	___ ___	HEPATITIS A,B, OR C	___ ___	RENAL DISEASE	___ ___	FAINTING/DIZZINESS
___ ___	HIGH BLOOD PRESSURE	___ ___	BLOODY SPUTUM	___ ___	THYROID DISEASE	___ ___	GLAUCOMA
___ ___	LOW BLOOD PRESSURE	___ ___	EMPHYSEMA	___ ___	PARATHYROID DISEASE	___ ___	NERVOUSNESS
___ ___	BLOOD DISEASE	___ ___	TUBERCULOSIS	___ ___	ARTHRITIS/GOUT	___ ___	PSYCHIATRIC CARE
___ ___	UNEXPLAINED FEVER	___ ___	CANCER	___ ___	RHEUMATISM	___ ___	ALZHEIMERS DISEA
___ ___	BRUISE EASILY	___ ___	XRAY/RADIATION	___ ___	PAIN IN JAW JOINTS	___ ___	NIGHT SWEATS
___ ___	ANEMIA	___ ___	CHEMOTHERAPY	___ ___	ARTIFICIAL JOINT	___ ___	ASTHMA
___ ___	EXCESSIVE BLEEDING	___ ___	INTESTINAL DISEASE	___ ___	VENEREAL DISEASE	___ ___	TATTOOS

DO YOU HAVE ANY OTHER SYMPTOMS OR ILLNESSES THAT ARE NOT LISTED ABOVE: YES / NO

EXPLAIN: _____

TO THE BEST OF MY KNOWLEDGE ALL OF THE INFORMATION ON THIS FORM IS CORRECT. IF I HAVE ANY CHANGE IN MY HEALTH STATUS, I SHALL INFORM THE DENTIST AND STAFF AT THE NEXT APPOINTMENT.

X _____ _____
PATIENT SIGNATURE (PARENT OR LEGAL GUARDIAN) DATE

_____ _____
REVIEWED BY DOCTOR DATE

MEDICAL UPDATES:

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE:	EXCEPTIONS:	PATIENT SIGNATURE:	BP:	REVIEWED BY:
_____	_____NONE_____	_____	_____	DR. _____
_____	_____NONE_____	_____	_____	DR. _____