REGISTRATION

Patient's Name_____

FIRST MIDDLE LAST

Address_____

City_____State_____Zip_____

Home Phone_____Work Phone_____Cell Phone_____

Male_____Female_____ Date of Birth_____SS#_____

Single____Married____ Name of Spouse_____

E-mail address_____

Patient employed by_____May we call you at work?_____

Previous Dentist_____When were your last x-rays?_____

In case of emergency, notify_____Phone #_____

How did you heard about us?

___friend or family_____
___Insurance website
___The Dispatch
___Lexington Phone Book
___Our website (SarahFryeDDS.com)
___Salisbury Phone Book
___other_____

DENTAL INSURANCE INFORMATION

Name of policyholder_____

Employer_____

Insurance Company_____

Policyholder's SS#_____

Policyholder's date of birth_____

As a courtesy to you we will file your primary dental insurance. Because we do not know exactly what your insurance will cover, we ask that you pay your "estimated" portion at the time of service. You will be responsible for payment of insurance portions older than 60 days. Interest of 1.5% per month (18% APR) or a minimum $2.00 monthly billing charge will accrue on account balances after 60 days.

Signature _____Date_____

Name:_____Date of Birth:_____

HEALTH QUESTIONNAIRE

Chief Complaint (Why are you seeking dental care?)_____

Current State of Health

Are you in good health?.....Yes No

Are you currently under the care of a physician…….....Yes No

Please list your family physician and any medical specialists you see at least once a year: (Please print)

Name Address City Phone# Name of Specialty

Circle Below:

MEDICAL HISTORY

1. Do you have (or have you ever had) any of the following:

Yes No a. allergic reaction to drugs or latex (Circle all that apply)
Latex Penicillin Aspirin Codeine Local Anesthetics Other

Yes No b. Immunosuppressive condition (Circle all that apply)
Steroid Therapy (e.g. prednisone) Radiation or Cancer Therapy SLE (Lupus) Rheumatoid Arthritis
HIV Organ Transplant Spleen removed Other

Yes No c. artificial joint(s) (Circle all that apply)
Hip Knee Ankle Shoulder
Date(s) placed:_____ _____ _____ _____

Yes No d. other artificial implants or devices

Yes No e. long term antibiotic use (greater than one month continuously)

Yes No f. nervous system disease or seizures

Yes No g. muscle or joint disease

Yes No h. mental health condition – specify _____

Yes No i. physical or mental disabilities that may require special care

Yes No j. Impairment of hearing, sight, or speech

Yes No 2. Have you ever been hospitalized or had surgery?
Describe:

Yes No 3. Do you have any undiagnosed symptoms?
Describe:

Yes No 4. Are you, or have you ever been addicted to a chemical substance?
(examples: alcohol, prescription drugs, heroin, meth, cocaine, other)

Yes No 5. Do you currently drink alcohol or use recreational drugs?

Yes No 6. Do you smoke or use smokeless tobacco?

Yes No 7. What type of tobacco product(s) do you use? _____ __

Yes No 8. How interested are you in stopping your tobacco use? (circle one)
Very interested Somewhat interested Not at all interested

Yes No 9. Do you regularly take herbal medicines or dietary supplements?
Specifically, do you take (circle all that apply):
Echinacea Garlic Ginger Kava Valerian
Feverfew Gingko Ginseng St. John's Wort Vitamin E

Yes No 10. Have you undergone current or past osteoporosis therapy?
(Examples are: Foxamax, Actonel, Boniva pill form)

Yes No 11. Have you undergone current or past therapy to reduce high blood calcium (bisphosphonate therapy)?
(Examples: intravenous Aredia, Zometa)

Yes No 12. Do you have any disease, condition, or problem not listed here?
Describe:

List below all medications you are currently taking.

_____

_____

_____

_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○Yes ○No	Cortisone Medicine	○Yes ○No	Hemophilia	○Yes ○No	Renal Dialysis	○Yes ○No
Alzheimer's Disease	○Yes ○No	Diabetes	○Yes ○No	Hepatitis A	○Yes ○No	Rheumatic Fever	○Yes ○No
Anaphylaxis	○Yes ○No	Drug Addiction	○Yes ○No	Hepatitis B or C	○Yes ○No	Rheumatism	○Yes ○No
Anemia	○Yes ○No	Easily Winded	○Yes ○No	Herpes	○Yes ○No	Scarlet Fever	○Yes ○No
Angina	○Yes ○No	Emphysema	○Yes ○No	High Blood Pressure	○Yes ○No	Shingles	○Yes ○No
Arthritis/Gout	○Yes ○No	Epilepsy or Seizures	○Yes ○No	Hives or Rash	○Yes ○No	Sickle Cell Disease	○Yes ○No
Artificial Heart Valve	○Yes ○No	Excessive Bleeding	○Yes ○No	Hypoglycemia	○Yes ○No	Sinus Trouble	○Yes ○No
Artificial Joint	○Yes ○No	Excessive Thirst	○Yes ○No	Irregular Heartbeat	○Yes ○No	Spina Bifida	○Yes ○No
Asthma	○Yes ○No	Fainting Spells/Dizziness	○Yes ○No	Kidney Problems	○Yes ○No	Stomach/Intestinal Disease	○Yes ○No
Blood Disease	○Yes ○No	Frequent Cough	○Yes ○No	Leukemia	○Yes ○No	Stroke	○Yes ○No
Blood Transfusion	○Yes ○No	Frequent Diarrhea	○Yes ○No	Liver Disease	○Yes ○No	Swelling of Limbs	○Yes ○No
Breathing Problem	○Yes ○No	Frequent Headaches	○Yes ○No	Low Blood Pressure	○Yes ○No	Thyroid Disease	○Yes ○No
Bruise Easily	○Yes ○No	Genital Herpes	○Yes ○No	Lung Disease	○Yes ○No	Tonsillitis	○Yes ○No
Cancer	○Yes ○No	Glaucoma	○Yes ○No	Mitral Valve Prolapse	○Yes ○No	Tuberculosis	○Yes ○No
Chemotherapy	○Yes ○No	Hay Fever	○Yes ○No	Pain in Joints	○Yes ○No	Tumors or Growths	○Yes ○No
Chest Pains	○Yes ○No	Heart Attack/Failure	○Yes ○No	Parathyroid Disease	○Yes ○No	Ulcers	○Yes ○No
Cold Sores/Fever Blister	○Yes ○No	Heart Murmur	○Yes ○No	Psychiatric Care	○Yes ○No	Venereal Disease	○Yes ○No
Congenital Heart Disorder	○Yes ○No	Heart Pace Maker	○Yes ○No	Radiation Treatments	○Yes ○No	Yellow Jaundice	○Yes ○No
Convulsions	○Yes ○No	Heart Trouble/Disease	○Yes ○No	Recent Weight Loss	○Yes ○No		

Have you ever had any serious illness not listed above? ○Yes ○No If yes, please explain:_____

_____

DENTAL HISTORY

Circle below:

Yes No 13. Do you have regular dental check-ups? Date of last exam:_____

Yes No 14. Have you had any trouble associated with previous dental treatment: (If "yes" explain.)

Yes No 15. Have you noticed any lumps or sores in your mouth?

Yes No 16. Do your gums bleed when you brush your teeth?

Yes No 17. Do you suffer from pain in the mouth, face, eyes, neck or throat?

Yes No 18. Are you happy with the appearance of you teeth?

Yes No 19. Do you want to save your teeth?

Yes No 20. Has fear prevented you from seeking dental treatment

Yes No 21. Are you allergic to any metals or dental materials?

Yes No 22. Circle the types of dental treatment you have experienced:

Orthodontics (braces) Dentures Root canal treatment Implants

Oral Surgery Periodontal (gum) treatment TMJ treatment Fillings

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT _____DATE_____