PATIENT REGISTRATION FORM

Dr. Alan Reisman, DDS
1075 South Boulder Road, Suite #135
Louisville, CO 80027
303-665-2377

Today's Date: _____

Patient Information

Patient's Name _____
Last First MI

Prefers to be called _____

Male ❑ Female ❑

Single ❑ Married ❑ Divorced ❑ Widowed ❑ Minor ❑

Street Address _____

City _____ State ____ Zip _____

Birthplace _____ Date of Birth _____ Age _____

Phone # _____ Work # _____

Present Complaint _____

_____

Employer _____

Occupation _____

Who referred you to this office? _____

General dentist's name _____

Contact Person not living with you _____

Address _____

_____

Phone _____

Responsible Party Information

Person Responsible for Bill _____

Relationship to patient _____

Social Security No. _____

Address (if different than patient) _____

_____

Phone (if different than patient) _____

Employer _____ W # _____

Primary Dental Insurance Coverage Information

Insured's Name _____

Soc. Sec. No. _____ Date of Birth _____

Employer _____

Name of Insurance Co. _____

Ins. Co. Phone _____ Plan/ID No. _____

Secondary Dental Insurance Coverage Information

Insured's Name _____

Soc. Sec. No. _____ Date of Birth _____

Employer _____

Name of Insurance Co. _____

Ins. Co. Phone _____ Plan/ID No. _____

Medical Insurance Coverage

Insured's Name _____

Insured's Date of Birth _____

Employer _____

Social Sec. No. _____

Name of Insurance Co. _____

Phone _____ Plan/ID No. _____

Method of Payment

Credit Card ❑ Cash/Check ❑

Please Turn Over ➥

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)
All answers are kept confidential

1. Are you in good health? Y N

2. Has there been any change in your general health in the past year? Y N

3. Date of last physical exam: _____

4. Are you now under a physician's care for a particular problem? Y N
   If yes, for what? _____

5. Have you had any serious illnesses, operations or hospitalizations? Y N
   If so, describe: _____
   _____

6. Have you had any adverse effects from dental treatment? Y N
   If yes, please describe:

7. List current medications: _____
   _____

8. Do you have or have you ever had any of the following:
   - A. Rheumatic fever or rheumatic heart disease? Y N
   - B. Congenital heart disease? Y N
   - C. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker installed)? mitral valve prolapse (MVP)? Y N
   - D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? Y N
   - E. Seizures, convulsions, epilepsy, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown? Y N
   - F. Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily? Y N
   - G. Blood Borne / Infectious diseases? Y N
   - H. Liver disease (jaundice, hepatitis)? Y N
   - I. Kidney disease? Y N
   - J. Diabetes? Y N
   - K. Thyroid disease? Y N
   - L. Arthritis? Y N
   - M. Stomach ulcers or colitis? Y N
   - N. Glaucoma? Y N
   - O. Frequent or recurring mouth sores? Y N
   - P. Implants placed in your body (heart valve, hip, knee)? Y N
   - Q. Radiation (x-ray) treatment for cancer? Y N
   - R. Clicking or popping of jaw joint, pain near ears, difficulty in opening mouth, grind or clench your teeth? Y N
   - S. Sinus or nasal problems? Y N
   - T. Any disease, drugs or transplant operation that may suppress your immune system? Y N
   - U. Recurring infections of any kind? Y N
   - V. Eating Disorder? Y N
   - W. Medicines for Osteoporosis (bisphosphonates)? Y N

9. Are you using or taking any of the following?
   - A. Tagamet? Y N
   - B. Thyroid medications? Y N
   - C. Antibiotics or sulfa drugs? Y N
   - D. Anticoagulants/blood thinners? Y N
   - E. High blood pressure medicine? Y N
   - F. Steroids, cortisone, etc.? Y N
   - G. Tranquilizers (valium, etc.)? Y N
   - H. Insulin, diabenese, or similar drug? Y N
   - I. Digitalis, inderal, nitroglycerin, calcium blockers, procardia or other heart medication? Y N
   - J. Aspirin or ibuprofen (motrin, naprosyn, etc)? Y N
     How much daily? _____
   - K. Antihistamines or other decongestants (seldane, etc)? Y N
   - L. Drug(s) to assist in weight loss or weight gain? Y N
   - M. Any other medications, pills or drugs, including "street drugs?" Y N
     If yes, please specify: _____
     _____
     _____

10. Are you allergic or have a bad reaction to:
    - A. Local anesthesia (novocaine, etc.)? Y N
    - B. Penicillin, amoxicillin, cephalosphorins or other antibiotics? Y N
    - C. Barbiturates, sedatives, etc.? Y N
    - D. Aspirin or ibuprofen? Y N
    - E. Codeine or other pain killers? Y N
    - F. Latex or rubber products? Y N
    - G. Other allergies or reactions? Y N
      If yes, please specify: _____

11. Do you wear contact lenses? Y N

12. Do you smoke or chew tobacco? How much daily? _____ Y N

13. Do you use alcohol? How much? _____ Y N

14. Have you ever sought professional care for drug abuse, alcoholism, or emotional disorders? Y N

15. WOMEN: Are you pregnant or planning pregnancy? Y N
    Are you taking any birth control pills? Y N
    Are you taking hormone replacements? Y N

16. Do you have any other disease, condition or problem not listed here that you think the doctor should know about? Y N
    If yes, please specify: _____

17. Do you wish to talk with the doctor privately about anything? Y N

I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. The information I have provided here is complete and accurate.

Patient/Guardian's Signature _____ **Date** _____

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