PATIENT REGISTRATION FORM

Dr. Alan Reisman, DDS

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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_____

Orthodontist name_____

Contact person not living with you_____

Address_____

_____

Phone_____

Responsible Party Information

Person responsible for the bill_____

Relationship to patient_____

Social Security Number_____

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 Date of Birth_____

Employer_____

Social Sec. No._____

Name of Insurance Co._____

Ins. 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), sleep apnea? 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 (juandice, 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, knee, hip)? 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 medications? 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**_____