Dentistry by Oselka

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name_____ Name I prefer to be called _____
FIRST MI LAST

Address _____City_____ State_____ Zip Code_____

E-mail _____

Home phone _____-_____-_____ Cell phone _____-_____-_____

May we call you at work? ☐ Yes ☐ No Work phone _____-_____-_____

Social Security # _____-_____-_____ Date of Birth _____/_____/_____ ☐ Male ☐ Female

Marital Status (check one) ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name _____ If Minor, Responsible Party _____

Emergency Contact _____ Phone _____-_____-_____

Employer _____ Occupation _____

Whom may we thank for referring you? _____ Hobbies or Interests: _____

DENTAL HISTORY

The date of your last dental visit – if not at this office: _____

Name of your last dentist: _____ City: _____

Why did you leave your last dentist? _____

Is there anything we can do differently? _____

What is your main dental concern? _____

Are you having any dental problems/pain with your teeth? ☐ YES ☐ NO If yes, please provide details_____

_____

How would you describe the condition of your teeth and gums? ☐ GOOD ☐ FAIR ☐POOR

How often do you brush your teeth? _____ Floss your teeth? _____

Do your gums bleed when you brush your teeth? YES NO When you floss? YES NO

Do you clench or grind your teeth? YES NO

Have you ever experienced pain in your jaw? YES NO

Have you ever been treated for TMD/TMJ symptoms? YES NO

Do you drink soda? YES NO If yes, amount per day: _____

Are you interested in a treatment for bad breath? YES NO

Are you interested in a non-surgical approach to stop snoring? YES NO

Are you happy with your smile? YES NO

Would you be interested in easily straightening your teeth without traditional metal braces? YES NO

Would you be interested in easily and safely whitening your teeth? YES NO

Would you be interested in having an oral cancer screening? YES NO

If you could easily change anything about the appearance of your smile, what would you choose to do? _____

_____

Do you need to be pre-medicated with antibiotics before dental treatment? YES NO NOT SURE

FOR **WOMEN** ONLY:

Are you pregnant? YES NO If yes, when is your due date? _____

Are you taking oral contraceptives? YES NO

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. To receive treatment from this office, you need to answer all applicable questions on this form. For your safety, honest answers to the medical questions are important and will be kept confidential.

MEDICAL HISTORY

Name of personal Physician: _____ Telephone: _____

Are you currently under a physician's care? ☐ Yes ☐ No If yes, please explain _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain _____

Have you ever a serious head or neck injury? ☐ Yes ☐ No If yes, please explain _____

Are you currently taking any medications including non-prescription? ☐ Yes ☐ No If yes, please list below:

Name of Medication	Purpose	Name of Medication	Purpose

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No _____

Do you use tobacco? ☐ Yes ☐ No If yes, how often? _____

Do you use controlled substances? ☐ Yes ☐ No If yes, how often? _____

Are you allergic to any of the following?

☐ Asprin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other please explain:

Do you have, or have you had, any of the following? ☐ Yes ☐ No **If yes, please check all that apply:**

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments	☐ Yellow Jaundice
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss	
☐ Anaphylaxis	☐ Drug addiction	☐ Hepatitis B or C	☐ Renal Dialysis	
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever	
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatism	
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever	
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles	
☐ Artificial Joint	☐ Excessive Thirst	☐ Hypoglycemia	☐ Sickle Cell Disease	
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Sinus Trouble	
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Spina Bifida	
☐ Blood Transfusion	☐ Frequent diarrhea	☐ Leukemia	☐ Stomach/Intestinal Disease	
☐ Breathing Problem	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke	
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs	
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease	
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tonsillitis	
☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tuberculosis	
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tumors or Growths	
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Ulcers	
☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Venereal Disease	

Have you ever had a serious illness not listed above? ☐ Yes ☐ No _____

OUR DISCLOSURE OF MEDICAL INFORMATION

By signing this form, you are consenting to our disclosure of your dental records to carry out treatment, payment activities and health care operations as set forth in our Privacy Practices Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law.

I certify that my answers to the above questions are correct to the best of my knowledge.
I understand this information will be held in confidence and will only be used to improve communication between Dr. Oselka, his staff and myself.
Dr. Oselka will not to be held responsible for any complication resulting from my failure to fill out this form accurately and honestly.

Print Name _____

Signature _____ Date _____