Emporia Family Dental Care

PATIENT REGISTRATION

Date: _____/_____/_____

1507 W. 12th Ave.
Emporia, KS 66801
620-342-0673

Name: _____ Date of Birth _____/_____/_____
(Last) (First) (Middle)

Social Security #: _____-_____-_____ Sex: M F_____ Marital Status: S M D W

Address: _____ City_____ State/Zip_____ Phone #: (h/w/c)_____

(h/w/c) _____Email: _____Employer:_____

May we contact you regarding upcoming appointments and/or reminders via email? Y N

In event of emergency, please contact: _____Phone:_____Relationship:_____

Who may we thank for referring you to our office?_____

Person Responsible for account: Self Other (please complete):

Name: _____ City/State/Zip _____

Phone: _____SSN:_____-____-_____ Relationship to Patient _____

Dental History:

When was your last dental visit? ____/____/____ For: _____ Where: _____

Are you uncomfortable currently? Y N Any Dental Complaints? (Circle all that apply): bleeding gums, changing bite, clenching/grinding, sore jaws, food packing between teeth, sensitive to cold, heat, pressure, sweets.

Notes: _____

_____

Have you ever had an adverse reaction to local anesthetics? Y N _____

Appearance: Are you happy with your smile? Y N If not, what would you change? Color, shape, spacing, other_____

_____

Do you have any questions about dentistry that we could answer for you? _____

_____

Please explain what you do to take care of your teeth/gums/mouth: _____

_____

Patient's Physicians: Primary Care _____

Specialist(s) _____ Last physical exam: ___/___/___ Findings:_____

_____

Are you being treated by a physician now? _____

_____

Have you been hospitalized recently? Any Serious Illness? _____
_____
_____

Have you had an orthopedic total joint replacement (hip, knee, etc.)? Y N If Yes, please explain, including date of surgery: _____
_____

Do you take pre-medication for your joint replacement? If yes, please list. _____
Do you take pre-medication for any heart condition? If yes, please list. _____
Do you take a blood thinner? If yes, please list. _____
Do you have any allergies to the following: Pencillin___Aspirin___Sulfa___Codeine___Bleach___ Anesthesia___Latex____Other_____

Medication:

Prescription Medications	Amount	#Day	Over the counter products	Amount	#Day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Do you use tobacco? Y N How much? _____
Alcohol? Y N How much? _____
Other habitual substances? Y N *What* and how much? _____

Do you have a history of, or problem with, anything listed below: (Check all that apply)

	Yes	No		Yes	No		Yes	No
Heart Problems	____	____	Kidney Disease	____	____	Cancer	____	____
Heart Valve Replacement	____	____	Genital/Urinary	____	____	Type of Cancer _____		
Angina or Chest Pain	____	____	STD's	____	____	Chemo or Radiation Therapy_____		
Heart Murmur	____	____	Positive HIV/AIDS	____	____	Other Therapy _____		
Rheumatic Fever	____	____	Stomach/Intestinal	____	____	**Males:**		
Swelling in Ankles	____	____	Other Digestive	____	____	Prostrate Trouble	____	____
Arteriosclerosis	____	____	Bleeding/Clotting	____	____	**Females:**		
Rheumatoid Arthritis	____	____	Autoimmune Diseases	____	____	Are you pregnant?	____	____
High/Low Blood Pressure	____	____	Stroke	____	____	Post-menopause?	____	____
Skin Diseases	____	____	Tuberculosis	____	____	Hormone Replacement Therapy?	____	____
Glaucoma/Eyes	____	____	Osteoarthritis	____	____	Other Conditions Not Listed: _____		
Shortness of Breath	____	____	Osteopenia	____	____	_____		
Asthma	____	____	Persistent Cough	____	____	_____		
Seasonal Allergies	____	____	Emphysema/COPD	____	____			
Sleep Apnea	____	____	Do you snore?	____	____			
Ear, Nose, Throat	____	____	Type I Diabetes	____	____			
Endocrine Diseases	____	____	Type II Diabetes	____	____			
Thyroid Disease	____	____	Hepatitis	____	____			
Liver Disease	____	____	Epilepsy/Seizures	____	____			
Fainting/Dizziness	____	____	Frequent Headaches	____	____			
Emotional Stress	____	____	Depression	____	____			
Other Mental Illness	____	____	Serious Head/Neck Injury	____	____			

Signature _____ Date _____