Patient Registration

Jenison Family Dentistry

Welcome to our practice. The benefits of a happy healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for your dental needs.

ABOUT YOU

TODAY'S DATE : _____

NAME: _____ Preferred Name: _____

First MI Last

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext# _____

E-Mail Address: _____ Would you like e-mails on office updates? ☐ Yes ☐ No

Birth Date: _____/_____/_____ Social Security # _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Separated

What is the reason for your visit to our office today _____

Referral: How did you hear about us? _____

Previous Dentist: _____ Last Visit Date: _____

Spouse / Guardian Information:

His / Her Name: _____ Employer: _____ Work Phone: _____ Ext# _____

Social Security # _____ Birth Date: _____/_____/_____

Employment:

Employer: _____ Occupation: _____ How long there? _____ ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time School Name: _____ City, State: _____

DENTAL INSURANCE INFORMATION

Primary:

Name of Insured: _____ Relationship to insured Self Spouse Child Other

Insured's SSN or ID _____ DOB _____/_____/_____ Relation _____

Insured's Employer: _____ Insurance Company Name: _____

Phone # _____ Group # _____

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone: _____ Date of last visit _____

I give Permission for Jenison Family Dentistry to obtain medical information from my Physician if needed:: Initials:_____

EMERGENCY CONTACT

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____

Relation: _____

Wk# _____ Hm # _____

Name_____ **DOB**_____ **Date**_____

HEALTH HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, _____
Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, _____
Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes, _____
Are you on a special diet? ☐ Yes ☐ No If yes, _____
Do you use tobacco? ☐ Yes ☐ No If yes, _____
Do you use controlled substances? ☐ Yes ☐ No If yes, _____
Do you experience dry mouth or bad breath? ☐ Yes ☐ No If yes, _____
Do your gums ever bleed? ☐ Yes ☐ No If yes, _____

Women: Are you Pregnant ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

ALLERGIES

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa ☐ Clindamycin ☐ Dental Anesthetics
☐ Tetracycline ☐ Erythromycin ☐ Jewelry ☐ Ibuprofen ☐ Keflex ☐ Other _____

HEALTH HISTORY

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

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

Sleep Apena Screening:
Do you snore? _____
Are you tired, fatigued or sleepy during the day? _____
Do you have high blood pressure? _____
Do you gasp while sleeping? _____
Have you had a home sleep study? _____
How long ago? _____

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 health. It is my responsibility to inform the dental office of any changes in medical condition. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I understand that I am responsible for payment of services rendered and also responsible for paying and co-payment and deductibles that my insurance does not cover. Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Signature of Patient, Parent or Guardian _____ Date: _____