RED BANK ENDODONTICS

REGISTRATION/ MEDICAL DENTAL HISTORY FORM

Date _____

PLEASE PRINT

Patient Name _____ SS# _____

Address_____ Name of Spouse/Parent _____

City _____ State_____ Zip_____ Spouse/Parent's Occupation _____

Home Telephone # _____ Work Phone # _____

Cell phone #_____ Employed by _____

Email _____ Employer's address _____

Birth Date _____ Sex _____

☐ Single ☐ Married ☐ Widowed ☐ Other Have you been a patient in this office before? _____

Your Occupation _____

Work Phone # _____ Referring Dentist _____

Employed by _____ Physician _____

Employer's address_____

_____

Whom may we contact in case of an emergency? _____

Emergency contact phone # _____

Patient Name _____ Date _____

Allergies to: PreMed required? Yes ☐ No ☐

Latex: Yes ☐ No ☐ Reason _____

Medications _____ Type _____ Dosage _____

Other_____

Have you ever had a reaction to Novocaine or nitrous oxide? Yes ☐ No ☐

Current Medications (Prescription, over the counter, and herbal)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

PAST AND CURRENT MEDICAL CONDITIONS (Check YES for all that apply)

Under physician's care Details:		Asthma	
Hospitalization/operation(s) in the last 5 years Details:		Sleep Apnea	
years		Tuberculosis	
Head/ neck/ mouth injuries		Sinus trouble	
Women: Pregnant		Cancer	
Women: Nursing		Radiation treatment to Head/Neck	
Women: Oral contraceptives		Chemotherapy	
Heart trouble/disease		Kidney Disease	
Rheumatic fever		Dialysis	
Past use of Fenphen		Eating Disorder	
Heart murmur		Stomach: Reflux __ Ulcer__	
Mitral valve prolapse		Immunological disease	
Heart surgery		Sjogrens Disease	
Artificial heart valves		Fibromyalgia	
Pacemaker		Other autoimmune disease (lupus. Pemphilus)	
Indwelling defibrillator		Arthritis or other joint disorders	
Artificial joints		Diabetes: Type: Controlled: Y/N	
History of Organ Transplant		Headaches	
High blood pressure BP: /		Depression: Diagnosed	
Stroke		Other Psychiatric Disorders	
Bleeding problem		Neurologic Disease	
Hemophilia		Convulsions	
Anemia		Epilepsy/ seizures	
Leukemia		Cerebral Palsy	
Lung Disease		Fainting/ Dizziness	
Emphysema		Venereal Disease	
Shortness of Breath		AIDS/ HIV positive	
Glaucoma		Alcohol or chemical dependency	
Thyroid Disease		Hepatitis	

Patient Signature _____ Date _____