RED BANK ENDODONTICS

REGISTRATION/ MEDICAL DENTAL HISTORY FORM

Date _____

PLEASE PRINT

Patient Name _____

Address _____

City _____ State___Zip_____

Home Telephone#_____

Cell phone #: _____ Email: _____

Birth Date _____ Sex _____

☐Single ☐Married ☐Widowed ☐Other

Your Occupation_____

Work Phone#_____

Employed by _____

Employer's Address _____

SS# _____

Name of Spouse/Parent _____

Spouse or Parent's Occupation_ _ _ _ _ _ _ _ _ _ Work Phone#_ _ _ _ _ _

Employed by _

Employer's Address_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Have you been a patient in this office before? _____

_____

Referring Dentist _____

Physician _____

Whom may we contact in the case of an emergency?

_____

Emergency contact Phone#

_____

MEDICAL DENTAL HISTORY FORM

Patient Name: **Date of Birth:**

Allergies to:

Latex: Yes ☐ No ☐

Medications_____

Other _____

PreMed Required? Yes ☐ No ☐

Reason: _____

Type:_____ Dosage:____

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	

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

Patient Signature: _____ Date: _____