PATIENT REGISTRATION FORM

Dr. Sophia Beason- Brown

Name_____
last first

Address_____

Phone_____
Home business cell

Date of birth_____ Social Security #_____

Occupation_____ Employer_____

Spouse's name_____ Spouse's employer_____

Person responsible for account_____

Dental Insurance plan and number_____

Physician's name_____

Were you referred to the office_____ by whom _____

Emergency contact person _____ telephone number_____

HEALTH HISTORY

When was your last visit to your physician and reason? _____

Have you ever been hospitalized? _____

Have you ever been seriously ill? _____

Has there been a change in your health in the past year? _____

Are you under medical treatment now? _____

Please check the conditions you now have or have had in the past.

High or low blood pressure_____

Abnormal or prolonged bleeding _____

Hepatitus or jaundice _____

Heart murmur _____

Pacemaker or difibulator _____

HIV or Aids _____

Asthma _____

Liver disease _____

Diabetes _____

Cancer _____

Arthritis or joint problems_____

Osteoporosis _____

Sexually transmitted disease _____

Seizures (epilepsy), fainting spells _____

Stroke _____

Heart disease _____

Mitral valve prolapse _____

Drug addiction _____

Thyroid problem _____

Kidney disease _____

Prosthesis (Heart valve or joint) _____

Radiation _____

Tuberculosis _____

If any of the above conditions have been checked, please describe.

_____

_____

_____

_____

MEDICATION AND DRUG HISTORY: What medications are you taking now? Including any over the counter drugs like aspirin, antihistamines, birth control pills, etc. (List medications, when taken and why taken)

_____

_____

What drugs are you allergic to?_____

When was the last time you had penicillin?_____Did you have any reaction?_____

Are there any medications that you cannot take or have been told not to take?_____

Do you smoke?_____ How much?_____ Women:are you pregnant?_____

Is there anything else the dentist should know before beginning treatment?_____

_____

DENTAL HISTORY

Reason for seeking dental care at this time:_____

Date of last visit to the dentist:_____

Reason for that visit and treatment performed:_____

Date of last dental xrays:_____

Outcome of previous extractions: Uneventful_____Excessive bleeding_____Dry socket_____

Have you ever had: Sensitive teeth_____Bleeding gums_____Painful areas in mouth_____

Unpleasant taste in mouth:_____ If yes, please describe_____

Do you have concerns about your teeth regarding: Chewing ability_____ _ Speech_____ Comfort_____

Cosmetic appearance_____If yes, please describe:_____

Do you have difficulties opening your mouth wide?_____

Do your jaws "pop or click" when opening wide?_____

Do you clench or grind your teeth while awake or asleep?_____

Do you breathe through your mouth while awake or asleep_____

Have you ever had injury to your face, jaws or teeth?_____

I give permission for diagnosis and/or treatment in this dental office for myself or the minor patient names below.

Date_____Signature of parent/guardian_____