Laurelwood Dental

Adult Registration

About You

Today's Date:____________________ E-mail Address ____________________

Name: ____________________ ____ I prefer to be called: ________________ male____ female____

Last First MI

Birthdate: ____/____/____ SSN: ________________ Single ____ Married ____

Home Address: ______________________________________

Street City State Zip

Home Phone #: (____)________ Cell#: (____)________ Work#: (____)________ When are best times to reach you?__________

Whom may we thank for referring you? ____________________ **or** ____________________

Friend/Relative/Doctor Internet Site

Employer: ____________________ How long there? ________ Occupation: ________________

Employer's Address

____

Street / PO Box City State Zip

Contact Information In Case of Emergency

His / Her Name: ____________________ Relationship: __________ Phone #: (____)__________

Address: ______________________________________

Street City State Zip

Spouse Information

His / Her Name: ____________________Birthdate: ____/____/____ Social Security #:________________

Employer: ________________________Work Phone #: (____)____________ Ext: ________

Dental Insurance Information

Primary Insurance Company: ________________ Phone # (____)__________ Group / Plan #: __________

ID#: ________________ Insured's Employer: ________________________

Insurance Co. Address: ______________________________________

Street / PO Box City State Zip

Insured's Name: ________________ Insured's SS#: __________ Insured's Birthdate ____/____/____ Relation: ________

Secondary Insurance Company: ________________ Phone # (____)__________ Group / Plan #: __________

ID#: ________________ Insured's Employer: ________________________

Insurance Co. Address: ______________________________________

Street / PO Box City State Zip

Laurelwood Dental

Adult Health Questionnaire

Today's Date: ______________

Address: ______________________________

Patient name: ______________

Phone: ______________ Email: ______________

Date of birth: ______________

The purpose of the following questions is to determine if you have a medical condition that may require special care. All information is confidential and kept in your dental record.

Name of physician: ______________________ Physician phone: ______________

Are you allergic to any of the following? (Check any that apply)

YES	NO		YES	NO		YES	NO	
☐	☐	LATEX RUBBER	☐	☐	SULFA	☐	☐	PENICILLIN
☐	☐	IODINE	☐	☐	ASPIRIN	☐	☐	CODEINE
☐	☐	DENTAL ANESTHETICS						

YES	NO	
☐	☐	Are you allergic to other medicines not listed? If yes, please list: ______________
☐	☐	Are you allergic to any foods or substances? If yes, please list: ______________

YES	NO	
☐	☐	Are you taking any prescription, over-thecounter, or herbal medicines? Please list: ______________
☐	☐	Are you being treated by a physician now?
☐	☐	Have you ever been treated with biphosphonate medications?
☐	☐	Have you ever had any injuries to your face or jaw?
☐	☐	Cigarettes: ______ packs per day, years smoked ______

PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

YES	NO	YEAR	CARDIOVASCULAR
☐	☐	______	HEART ATTACK
☐	☐	______	BLEEDING DISORDER
☐	☐	______	PACEMAKER
☐	☐	______	HEART DISEASE
☐	☐	______	HIGH BLOOD PRESSURE
☐	☐	______	HISTORY OF ENDOCARDITIS
☐	☐	______	ARTIFICIAL HEART VALVE
☐	☐	______	CONGENITAL HEART DEFECT
			NERVOUS SYSTEM
☐	☐	______	STROKE
☐	☐	______	CONVULSIONS/SEIZURES
☐	☐	______	ADD/ADHD
☐	☐	______	DEPRESSION

YES	NO	YEAR	PULMONARY
☐	☐	______	ASTHMA
☐	☐	______	TUBERCULOSIS
☐	☐	______	COPD
			IMMUNE SYSTEM
☐	☐	______	HIV POSITIVE
☐	☐	______	CANCER
☐	☐	______	RADIATION THERAPY
☐	☐	______	CHEMOTHERAPY
☐	☐	______	ORAL HERPES
☐	☐	______	ARTHRITIS
☐	☐	______	LUPUS
☐	☐	______	SJOGREN'S DISEASE
☐	☐	______	ORGAN TRANSPLANT

YES	NO	YEAR	ENDOCRINE
☐	☐	______	DIABETES
☐	☐	______	THYROID DISORDER
			HEPATORENAL
☐	☐	______	KIDNEY DIALYSIS (A-V SHUNT)
☐	☐	______	HEPATITIS B OR C
☐	☐	______	KIDNEY/LIVER DISEASE
			MISCELLANEOUS
☐	☐	______	ARTIFICIAL JOINTS
☐	☐	______	DRY MOUTH
☐	☐	______	UNEXPLAINED FEVER
☐	☐	______	UNEXPLAINED WEIGHT LOSS
☐	☐	______	DRUG/ALCOHOL DEPENDENCY
☐	☐	______	ULCERS

☐ ☐ IF FEMALE, ARE YOU PREGNANT? DUE DATE ______________

☐ ☐ IS THERE ANYTHING ELSE THAT YOU THINK WE SHOULD KNOW? IF YES, PLEASE EXPLAIN: ______________

I HAVE ANSWERED THESE QUESTIONS TO THE BEST OF MY KNOWLEDGE AND ABILITY.

I give consent for the administration of local anesthetics which are commonly used in dentistry to prevent pain. Risks of local anesthetic include allergic reactions, fainting, infection, hematoma (deep bruising, swelling and discoloration), and prolonged or permanent numbness. I have had the opportunity to discuss this with my dentist and may revoke this consent at any time.

X ______________________________ ______________

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

Changes ______________ Signature ______________ Date ______________

Changes ______________ Signature ______________ Date ______________

Changes ______________ Signature ______________ Date ______________