

Holton Dental

785-364-3038

Patient Registration Form

Welcome

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name (if different from name listed): _____

Address: _____ City: _____ State: _____ Zip: _____

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

Birth Date: _____ Social Security: _____ Drivers License: _____

Email: _____

Preferred Dentist: No Preference Dr. Gilliland Dr. Rieschick

Dental Insurance Information:

Insurance Carrier: _____

Employer: _____

Policy Holder Information: (if not patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Birth Date: _____ Social Security: _____ Drivers License: _____ Phone: _____

Previous Dentist or Dental Office that may have your past dental records or x-rays:

How did you hear about our office? _____

If someone referred you, whom may we thank for referring you to our office? _____

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Medical Health History

Patient Name: _____ Date: _____

Although we as dental professionals primarily treat your mouth, many health problems you have or medications you take can affect your dental care. Please answer the following to the best of your ability:

Are you under a physicians care now? Yes No
If yes, who and at what office? _____

Have you ever been hospitalized or had a major operation? Yes No
If yes, what/when? _____

Have you ever had a serious head or neck injury? Yes No
If yes, what/when? _____

Are you taking any medications, pills, or drugs? Yes No
If there are several, please feel free to list medications on the back of this form.

Do you take, or have you taken, Phen-Fen or Redux? Yes No
If yes, when? _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biphosphonates? Yes No
If yes, what/when? _____

Are you on a special diet? Yes No
If yes, please describe: _____

Do you use tobacco or E-Cigarettes? Yes No
If yes, indicate what type: _____
How long have you used this product? _____ How many packs/cans per day? _____

Do you use alcohol? Yes No
If yes, please clarify:
 Never Occasionally Monthly Weekly Daily 4+per Day

Do you use controlled substances? Yes No
If yes, please clarify: _____

Women: Are you

Pregnant Trying to get pregnant Nursing Taking oral contraceptives

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal
 Metal Latex Sulfa Drugs Local Anesthetics
 Other If yes, Please List: _____

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

AIDS/HIV Positive	<input type="radio"/> Yes	<input type="radio"/> No
Alzheimer's disease	<input type="radio"/> Yes	<input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes	<input type="radio"/> No
Anemia	<input type="radio"/> Yes	<input type="radio"/> No
Angina	<input type="radio"/> Yes	<input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes	<input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes	<input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes	<input type="radio"/> No
Asthma	<input type="radio"/> Yes	<input type="radio"/> No
Blood Disease	<input type="radio"/> Yes	<input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes	<input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes	<input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes	<input type="radio"/> No
Cancer	<input type="radio"/> Yes	<input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes	<input type="radio"/> No
Chest pain	<input type="radio"/> Yes	<input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes	<input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes	<input type="radio"/> No
Convulsions	<input type="radio"/> Yes	<input type="radio"/> No
Cortisone Medicine	<input type="radio"/> Yes	<input type="radio"/> No
Diabetes	<input type="radio"/> Yes	<input type="radio"/> No
Drug Addiction	<input type="radio"/> Yes	<input type="radio"/> No
Easily Winded	<input type="radio"/> Yes	<input type="radio"/> No
Emphysema	<input type="radio"/> Yes	<input type="radio"/> No
Epilepsy or Seizures	<input type="radio"/> Yes	<input type="radio"/> No
Excess Bleeding	<input type="radio"/> Yes	<input type="radio"/> No
Excessive Thirst	<input type="radio"/> Yes	<input type="radio"/> No
Fainting/Dizziness	<input type="radio"/> Yes	<input type="radio"/> No
Frequent Cough	<input type="radio"/> Yes	<input type="radio"/> No
Frequent Diarrhea	<input type="radio"/> Yes	<input type="radio"/> No
Frequent Headaches	<input type="radio"/> Yes	<input type="radio"/> No
Genital Herpes	<input type="radio"/> Yes	<input type="radio"/> No
Glaucoma	<input type="radio"/> Yes	<input type="radio"/> No
Hay Fever	<input type="radio"/> Yes	<input type="radio"/> No
Heart Attack/Failure	<input type="radio"/> Yes	<input type="radio"/> No
Heart Murmur	<input type="radio"/> Yes	<input type="radio"/> No
Heart Pacemaker	<input type="radio"/> Yes	<input type="radio"/> No
Heart Trouble/Disease	<input type="radio"/> Yes	<input type="radio"/> No

Hemophilia	<input type="radio"/> Yes	<input type="radio"/> No
Hepatitis A	<input type="radio"/> Yes	<input type="radio"/> No
Hepatitis B or C	<input type="radio"/> Yes	<input type="radio"/> No
Herpes	<input type="radio"/> Yes	<input type="radio"/> No
High Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No
High Cholesterol	<input type="radio"/> Yes	<input type="radio"/> No
Hives or Rash	<input type="radio"/> Yes	<input type="radio"/> No
Hypoglycemia	<input type="radio"/> Yes	<input type="radio"/> No
Irregular Heartbeat	<input type="radio"/> Yes	<input type="radio"/> No
Kidney Problems	<input type="radio"/> Yes	<input type="radio"/> No
Leukemia	<input type="radio"/> Yes	<input type="radio"/> No
Liver Disease	<input type="radio"/> Yes	<input type="radio"/> No
Low Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No
Lung Disease	<input type="radio"/> Yes	<input type="radio"/> No
Mitral Valve Prolapse	<input type="radio"/> Yes	<input type="radio"/> No
Osteoporosis	<input type="radio"/> Yes	<input type="radio"/> No
Pain in Jaw Joints	<input type="radio"/> Yes	<input type="radio"/> No
Parathyroid Disease	<input type="radio"/> Yes	<input type="radio"/> No
Psychiatric Care	<input type="radio"/> Yes	<input type="radio"/> No
Radiation Treatment	<input type="radio"/> Yes	<input type="radio"/> No
Recent Weight Loss	<input type="radio"/> Yes	<input type="radio"/> No
Renal Dialysis	<input type="radio"/> Yes	<input type="radio"/> No
Rheumatic Fever	<input type="radio"/> Yes	<input type="radio"/> No
Rheumatism	<input type="radio"/> Yes	<input type="radio"/> No
Scarlet Fever	<input type="radio"/> Yes	<input type="radio"/> No
Shingles	<input type="radio"/> Yes	<input type="radio"/> No
Sickle Cell Disease	<input type="radio"/> Yes	<input type="radio"/> No
Sinus Trouble	<input type="radio"/> Yes	<input type="radio"/> No
Spina Bifida	<input type="radio"/> Yes	<input type="radio"/> No
Stomach/Intestinal Disease	<input type="radio"/> Yes	<input type="radio"/> No
Stroke	<input type="radio"/> Yes	<input type="radio"/> No
Swelling of Limbs	<input type="radio"/> Yes	<input type="radio"/> No
Thyroid Disease	<input type="radio"/> Yes	<input type="radio"/> No
Tonsillitis	<input type="radio"/> Yes	<input type="radio"/> No
Tuberculosis	<input type="radio"/> Yes	<input type="radio"/> No
Tumors or Growths	<input type="radio"/> Yes	<input type="radio"/> No
Ulcers	<input type="radio"/> Yes	<input type="radio"/> No
Venereal Disease	<input type="radio"/> Yes	<input type="radio"/> No
Yellow Jaundice	<input type="radio"/> Yes	<input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No If yes, please clarify: _____

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____

Date: _____