Holton Dental

785-364-3038

Patient Registration Form

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

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