



www.canyonviewdental.com hello@canyonviewdental.com

REGISTRATION INFORMATION

DATE: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____ Birthdate: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____ Sex: M F
Email: _____ I would like to receive correspondence via mail via text
What is the best way to contact you? home phone cell phone work phone e-mail texting
Employer: _____ SSN: _____
Physician: _____ Phone Number: _____ Date of last visit: _____
Whom may we thank for referring you to our practice? _____

RESPONSIBLE PARTY (if different from above)

First Name: _____ Last Name: _____ Birthdate: _____
Address: _____ City/State/Zip: _____
Email: _____ I would like to receive correspondence via mail via text
Home Phone: _____ Work Phone: _____ Cell Phone: _____ Sex: M F
What is the best way to contact you? home phone cell phone work phone e-mail texting
Employer: _____ SSN: _____

EMERGENCY CONTACT INFORMATION

Name of Contact(s): _____
Home Phone: _____ Work/Cell Phone: _____ Relation: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to patient: Self Spouse Child Other
Insured SSN: _____ Policy/Group#: _____ Insured Birthdate: _____
Employer: _____ Insurance Company: _____
Address: _____ Address: _____
City/State/Zip: _____ City/State/Zip: _____
Do you have secondary insurance information? Y N If yes, name of insurance company: _____

DENTAL HISTORY

1. What brings you to our office today? _____
2. Are you currently in pain? Y N If yes, please describe location, type and duration of pain: _____
3. Have you ever had a serious/difficult problem associated with any previous dental work? Y N If yes, please explain: _____
4. Do you or have you ever experienced pain/discomfort in your jaw joint (TMD/TMJ) or do you have soreness in your mouth or jaw in the morning? Y N If yes, please describe: _____
5. You consider your current dental health to be: Good Fair Poor
6. Do you like your smile? Y N If no, why? _____
7. Do your gums ever bleed? Y N If so, when? _____
8. How often do you brush your teeth? _____ /day Type of toothbrush bristles: Hard Medium Soft
9. How often do you floss? _____ /day or week

PLEASE TURN OVER AND FILL OUT OTHER SIDE OF FORM

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Please answer Yes, No or N/A to each item. If you have questions, please let us know.

1. Are you under a physician's care now? Y N N/A _____
2. Have you ever been hospitalized or had a major operation? Y N N/A If yes, what for? _____
3. Have you ever had a serious head or neck injury? Y N N/A If yes, please explain _____
4. **Are you taking any medications, pills or drugs?** Y N N/A If yes, please list name of medication and dosage:

5. **Do you take, or have you taken, oral and/or IV osteoporosis/bisphosphonate medications** (i.e. Fosamax, Actonel, Boniva, Zometa, Aredia)? Y N N/A **If so, name of drug, when and for how long?** _____
6. Are you on a special diet? Y N N/A If yes, please specify _____
7. Do you use tobacco or smoke? Y N N/A If yes, how much and how often? _____
8. Do you use controlled substances? Y N N/A If yes, please list _____
9. For women only: are you -- Taking oral contraceptives? Pregnant/trying to get pregnant? Nursing?

Are you allergic to any of the following? **I do not have any allergies that I am aware of**

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____
If you have an allergy to any of the above or other substances, what type of reaction do you get? _____

Do you have, or have you had, any of the following? Please check all that apply.

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Cold Sore/Fever Blister | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder** | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestine Disease |
| <input type="checkbox"/> Artificial Heart Valve** | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Cholesterol | *New 2007 Guidelines - condition may require pre-medication to receive dental work | | | |

Have you had any serious illness that is not listed above? Y N If yes, please list _____

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. I furthermore understand that this information will be held in the strictest of confidence. I authorize the dental staff of Canyon View Dental, PC to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I understand that my signature for this document will also be recorded electronically in my file.

SIGNATURE (patient, parent/legal guardian): _____ **Date:** _____