ICONIC Periodontics and Dental Implants

PATIENT REGISTRATION FORM (CONFIDENTIAL)

Date: / /

PATIENT INFORMATION

LAST NAME	FIRST NAME	BIRTHDATE / /	SEX Male / Female
Address	City	State	Zip Code
Cell Phone ( ) -	Work Phone ( ) -	Home ( ) -	Email

Check Box: ☐ SINGLE ☐ MARRIED ☐ MINOR ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ OTHER

SSN	Employer	Referred by / How did you hear about our practice?
Emergency Contact	Phone Number ( ) -	Relationship to Patient

INSURANCE INFORMATION

Subscriber **LAST** NAME	**FIRST** NAME	MI	BIRTHDATE / /
Subscriber EMPLOYER	SSN	RELATIONSHIP	
Primary Insurance Name	ID#		Group #
Secondary Insurance Name	ID#		Group #

DENTAL HISTORY

ORAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

☐Y ☐ N Are you currently having dental discomfort? If yes, explain
☐Y ☐ N Any injuries to mouth/teeth/head? If yes, explain
☐Y ☐ N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y ☐ N Orthodontic appliances now or in the past?
☐Y ☐ N Gums bleed when brushing or flossing?
☐Y ☐ N Does it hurt to bite or chew?
☐Y ☐ N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y ☐ N

Any additional concerns/discomfort?

MEDICAL HISTORY

Physician's Name	Address	Phone#	Date of Last Visit

☐Y ☐ N Under a physician's care now? If Yes, explain_____
☐Y ☐ N Have you ever had any serious illness, hospitalization, or operations? If Yes, when _____
☐Y ☐ N Have you ever had blood transfusion? If Yes, give approximate dates _____
☐Y ☐ N Have you ever used any recreational drugs (e.g. Marijuana, Cocaine) or controller substances? If Yes, explain_____
☐Y ☐ N Have you ever been pre-medicated antibiotics for your dental treatment? If Yes, explain_____
☐Y ☐ N Do you use tobacco in any form? If Yes, explain_____

FEMALE PATIENT: ☐Y ☐ N Currently nursing? ☐Y ☐ N Currently pregnant? Due Date: / /

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MEDICAL HISTORY CONTINUED

ALL PATINETS: DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ NONE TO ALL

☐ AIDS/HIV	☐ DEPRESSION	☐ HIGH BLOOD PRESSURE	☐ SCARLET FEVER
☐ ANEMIA	☐ DIABETES	☐ JAUNDICE	☐ SHORTNESS OF BREATH
☐ ANXIETY	☐ DIZZINESS/FAINTING	☐ JAW PAIN	☐ SINUS PROBLEM
☐ ARTIFICIAL JOINTS	☐ EMPHYSEMA	☐ KIDNEY DISEASE	☐ SKIN RASH
☐ ARTHRITIS	☐ EPILEPSY/SEIZURES	☐ LIVER DISEASE	☐ STROKE
☐ ASTHMA	☐ FREQUENT EAR INFECTIONS	☐ LOW BLOOD PRESSURE	☐ SWOLLEN FEET/ANKLES
☐ BLEEDING DISORDER	☐ FREQUENT HEADACHES	☐ MITRAL VALVE PROLAPSE	☐ SWOLLEN NECK.GLANDS
☐ BLOOD DISEASE	☐ GLAUCOMA	☐ MONONUCLEOSIS	☐ THYROID PROBLEMS
☐ CANCER	☐ HEARING PROBLEMS	☐ OSTEOPOROSIS	☐ TONSILLTIS
☐ CEREBRAL PALSY	☐ HEART ATTACK	☐ PACEMAKER	☐ TUBERCULOSIS
☐ CHEMICAL DEPENDENCY	☐ HEART DISEASE	☐ PSYCHIATRIC	☐ TUMORS
☐ CHICKEN POX	☐ HEART MURMUR	☐ RADIATION TREATMENT	☐ UCLERS
☐ CONVULSIONS	☐ HEPATITIS TYPE ___	☐ RESPIRATORY DISEASE	☐ VENERAL DISEASE
☐ CORTISONE TREATMENT	☐ HERPES	☐ RHEUMATIC FEVER	☐ WEIGHTLOSS (SERVERE)

Please list any other condition not listed above:

_____

ALLERGY INFORMATION

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECH ALL THAT APPLY):

☐ NONE TO ALL

☐ ANTIBIOTICS/SULFA DRUGS	☐ BLOOD THINNERS	☐ INSULIN	☐ NITROGLYCERIN
☐ ANTIHISTAMINE/ALLERGY	☐ BL CANCER/CHEMO MEDICATIONS	☐ IODINE	☐ ORAL CONTRACEPTIVES
☐ ASPIRIN	☐ CORTISONE/STEROIDS	☐ LATEX	
☐ BARBITURATES	☐ CODEINE	☐ LOCAL ANESTHETIC	

Please list any other ALLERGY/ALLERGIC REACTION not listed above:

_____

_____

MEDICATION INFORMATION

List any medication you are currently taking:

_____

_____

By signing below, I certify that the information above is accurate and complete to the best of my knowledge:

Signature (If minor, Parent/Guardian signs below) Date Relationship

_____ _____/_____/_____ _____