Morristown Family Dentistry

Adult Registration

Date_____

Patient Name _____ Preferred Name_____
First Middle Last

SS#_____ Cell# (_____)_____ Birthdate_____ Age_____ Sex M or F

Marital Status: Single___ Married___ Divorced___ Widowed___ Spouse's Name: _____

Home Address_____ Zip _____

Prefer appointment reminder by (circle one) text email phone call

E- Mail Address _____Referred By _____

Emergency contact_____ Relationship _____cell #_____

Do you have dental insurance? YES_____ NO_____ With Whom? _____

What is the reason for your visit? _____

_____

Are you presently under the care of a physician? ..... Yes No

Explain_____

Name, address and phone number of physician _____

_____

Do you have or have you had any of the following diseases or problems?

1.	ADHD…….....	Yes	No
2.	Arthritis……	Yes	No
3.	Artificial Joints……...	Yes	No
4.	Asthma……..…	Yes	No
5.	High Blood pressure……..	Yes	No
6.	Cardiovascular disease……..	Yes	No
7.	Congenital heart lesions……	Yes	No
8.	Diabetes…….	Yes	No
9.	Fainting spells or seizures…….	Yes	No
10.	Hay fever……..	Yes	No
11.	Hepatitis, jaundice or liver disease	Yes	No
12.	HIV/AIDS……..	Yes	No
13.	Low Blood Pressure……..	Yes	No
14.	Psychiatric counseling……..	Yes	No
15.	Rheumatic fever …….	Yes	No
16.	Substance abuse (alcohol, drugs).	Yes	No
17.	Venereal disease……..	Yes	No
18.	Mitral Valve Prolapse…….	Yes	No

Do you use any form of tobacco?..... Yes No

Describe any heart condition?_____

Have you ever had a serious injury to the head, face, or jaw? Yes No

If so, please list_____

_____

Are you taking any over the counter medications?..... Yes No

If so, explain_____

_____

Have you ever had abnormal bleeding following a cut or extraction?..... Yes No

Is so, explain_____

Are you now taking**:**

1.	High blood pressure medication?.....	Yes	No
2.	Sleep medication?.....	Yes	No
3.	Cortisone, steroids or ACTH?.....	Yes	No
4.	Anticoagulants or blood thinner?.....	Yes	No
5.	Tranquilizers or sedatives?.....	Yes	No
6.	Antibiotics?.....	Yes	No
7.	Insulin?.....	Yes	No
8.	Have you ever taken Fen-Phen?.....	Yes	No
9.	Have you ever taken a Bisphosphonate?……	Yes	No

Antibiotic prophylaxis required?.....Yes No

List all current medications?

_____

_____

_____

Females only: Are you taking birth control?.....Yes No

Are you allergic to or have you reacted adversely to?

1.	Local anesthetics?	Yes	No
2.	Penicillin?	Yes	No
3.	Other antibiotics? Specify_____		
4.	Anticoagulants or blood thinner?	Yes	No
5.	Barbiturates, sedatives or sleeping pills?.....	Yes	No
6.	Aspirin?	Yes	No
7.	Iodine?.....	Yes	No
8.	Codeine?.....	Yes	No
9.	Latex?	Yes	No
10.	Nickel?	Yes	No
11.	Other_____		

Have you ever been under the care of a physician for any major illness or injury other than those noted above? If so, please list:

_____

_____

I hereby consent to all visits necessary to receive an oral evaluation, dental treatment and maintenance treatment and for the release of information of health conditions to official agencies and/or private doctors. To the best of my knowledge, the medical history is true and accurate. I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

SIGNATURE _____Date _____

Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA.