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 Employer_______________________

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? ____

Which pharmacy do you choose to use?____

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
   if yes, DATE:________
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

Have you ever had/been treated for head or neck cancer? Yes No

If yes to either question, 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 Fosamax or received a "shot for your bones"?..............................Yes No

Antibiotic prophylaxis required?.....................................Yes No

List all current medications?

____
____
____

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:

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FEMALES ONLY: Are you taking birth control?...........Yes No

Are you currently pregnant?............Yes No

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.