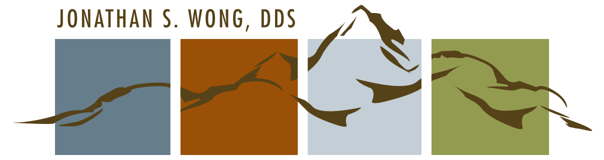

PATIENT REGISTRTION & HEALTH HISTORY FORM

INTEGRATED PERIODONTICS
& DENTAL IMPLANTS

Medical Alert For Office Use

Today's Date: ______________________

Who is your general dentist? ______________________

Patient Name: ____________ Nickname: ____________ Birth Date: ________ Age: ______ Sex: ❑ M ❑ F

Street Address: ______________________

City: ____________ State: ____________ Zip: ____________

Occupation: ____________ Emergency Contact & Phone #: ____________

Employer: ____________ Who may we thank you for referring you to our office? ____________

Employer Location: ____________ Driver's License #: ____________

Phone: Home ____________ Social Security #: ____________

Work ____________ May we contact you at work? ____________ ❑ Y ❑ N

Mobile ____________ Spouse's Name (or parent's if minor): ____________

Email Address: ____________ Spouse's Employer (or parent's if minor): ____________

Primary Dental Insurance

Subscriber Name: ____________ Social Security #: ____________ DOB: ____________

Employer: ____________ Insurance Company: ____________

Insurance Co. Phone #: ____________ Group #: ____________

Relation to patient: ______________________

Secondary Dental Insurance

Subscriber Name: ____________ Social Security #: ____________ DOB: ____________

Employer: ____________ Insurance Company: ____________

Insurance Co. Phone #: ____________ Group #: ____________

Relation to patient: ______________________

Insurance Authorization Statement (Please sign and date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs incurred during dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnosis and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signed: ______________________ Date: ____________

If Patient is Under 18 Years of Age

Responsible Party: ____________ Relation to Patient: ____________

Street Address: ______________________

City: ____________ State: ____________ Zip: ____________

Phone#: ______________________

1190 South Victoria Avenue, Suite 305 | Ventura, CA 93003 | 805.644.9664 Phone | 805.644.9667 Fax | www.wongperio.com

DENTAL HISTORY

Please check any of the following that apply to you:

- ❑ Currently experiencing dental pain/discomfort
- ❑ Sensitivity to cold, heat or sweets
  If yes, where? UR LR UL LL
- ❑ Headaches, earaches, neck pain
- ❑ Jaw joint pain
- ❑ Teeth or filling breaking
- ❑ Grinding or clenching of teeth
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, tipped or shifting teeth
- ❑ Bad breath,

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

- ❑ Dentures
- ❑ Partial dentures
- ❑ Braces
- ❑ Periodontal (gum) treatments

Please share the following dates:

Your last dental cleaning ____ / ____
Your last oral cancer screening ____ / ____
Your last complete X-rays ____ / ____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Y ❑ N

On a scale from 1 – 10, with 10 being the highest rating:

How important is your dental health to you?
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Where would you rate your current dental health?
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Where do you want your dental health to be?
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

What is your most important question or concern about your dental visit today?

____
____
____
____

MEDICAL HISTORY

Please check any of the following that apply to you.

- ❑ Abnormal Bleeding
- ❑ Alcohol Abuse
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chlamydia
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes (Type 1/Type 2)
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Excessive Bleeding
- ❑ Facial Surgery
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Gonorrhea
- ❑ HIV/AIDS
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Jaw Joint Pain
- ❑ Jaundice
- ❑ Joint Replacement
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Pace Maker
- ❑ Pregnant (Currently)
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Sexually Transmitted Disease
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Syphilis
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Fen/Phen Usage
- ❑ Bisphosphonate Usage (ie,Fosamax)

Do you have any of the following drug allergies?

- ❑ Aspirin
- ❑ Local Anesthetic
- ❑ Tetracycline
- ❑ Codeine
- ❑ Other:______________________________
- ❑ Erythromycin
- ❑ Penicillin
- ❑ Sulfa
- ❑ Latex

____

Are you currently under the care of a physician? If yes, explain. ❑ Y ❑ N

____

Physician's Name: ______________________________
Phone: ______________________________
Please list any medications you are currently taking: ______________________________

____

Treatment Authorization Form

I hereby authorize and give consent to perform dental services agreed upon between doctor and patient and/or parent or After thorough explanation and to be necessary and advisable, including any diagnostic aids deemed appropriate by the doctor and the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my dental health and medical condition. Payment for all services rendered are my responsibility.

Signature (Patient, Parent or Responsible Party): ______________________________
Relationship to Patient: ______________________________
Date: ______________________________