



PIKE DENTISTRY

Cosmetic & General Dentistry

PATIENT INFORMATION **PLEASE PRINT**

ADULT REGISTRATION

DATE: _____

FULL NAME: _____ HOME PHONE: _____

NICKNAME: _____ WORK PHONE: _____

STREET ADDRESS: _____ CELL PHONE: _____

CITY/STATE/ZIP: _____ EMAIL: _____

GENDER: M / F MARITAL STATUS S M D W SSN#: _____

WHOM MAY WE THANK FOR YOUR REFERRAL?: _____ DOB: _____

HEALTH INFORMATION

IT IS VERY IMPORTANT THAT WE KNOW ABOUT YOUR DENTAL/MEDICAL HISTORY. MANY THINGS HAVE A DIRECT BEARING ON DENTAL HEALTH/TREATMENT. ALL INFORMATION IS CONFIDENTIAL.

PHYSICIAN'S NAME: _____ PHONE: _____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE Y / N (Please circle one)

REASON(S): _____

CURRENT MEDICATIONS: _____

EVER HOSPITALIZED? Y / N (Please circle one) DATE(S) OF HOSPITALIZATION: _____

REASONS: _____

ANY SPECIAL NEEDS? _____

FINANCIAL RESPONSIBILITY/EMERGENCY INFORMATION

PERSON(S) FINANCIALLY RESPONSIBLE: _____ RELATION: _____

EMERGENCY CONTACT: _____ / TYPE OF RELATION: _____ PHONE: _____

PRIMARY INSURANCE INFORMATION

EMPLOYED BY: _____ WORK PHONE: _____

DENTAL INSURANCE CO: _____ INS. CO. PHONE: _____

NAME OF POLICY HOLDER: _____ POLICY HOLDERS SSN# _____

GROUP NUMBER: _____ POLICY HOLDERS DOB: _____

POLICY ID NUMBER: _____ RELATION TO POLICY HOLDER: _____

SECONDARY INSURANCE INFORMATION

EMPLOYED BY: _____ WORK PHONE: _____

DENTAL INSURANCE CO: _____ INS. CO. PHONE: _____

NAME OF POLICY HOLDER: _____ POLICY HOLDERS SSN# _____

GROUP NUMBER: _____ POLICY HOLDERS DOB: _____

POLICY ID NUMBER: _____ RELATION TO POLICY HOLDER: _____

HEALTH HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CHECK YES OR NO TO EACH.

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?"

These include combinations of Lonimim, Adipex, Fastin (phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis / Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV / Aids	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immune Deficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Autoimmune Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor / Malignancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Problems/Blood Thinners	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Replacement : Hip / Knee	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease/Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	DENTAL HISTORY	
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bad Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette / Pipe / Cigar / Dip	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding Gums	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blisters on Lips or Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Broken Fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clenching of Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clicking or Popping Jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No
Defibrillator/Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding of Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gums Swollen or Tender	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy / Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain / Jaw Tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or Cheek Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shunt Placed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches (____ x per month)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack (year:_____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Cold / Heat / Sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke (year:_____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or Growth in your Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Valve / Replacement Stent	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet / Ankles / Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hepatitis A / B / C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Taking Blood Thinner Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Taking Insulin	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Taking Medication for Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

WOMEN:

Are you pregnant? Yes No Due Date _____ Are you nursing? Yes No

Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbituates (Sleeping Pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

UPDATES (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No
 For what condition? _____

Are you taking any new medications? Yes No If so, what? _____

 Signature of Patient, Parent, Guardian or Personal Representative Date

Has there been any change in your health since your last dental appointment? Yes No
 For what condition? _____

Are you taking any new medications? Yes No If so, what? _____

 Signature of Patient, Parent, Guardian or Personal Representative Date