Adult Registration & Health Questionnaire

Tri-Cities Center for
Cosmetic Dentistry

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Welcome to our practice...

Thank you for selecting us. Please fill out this form in ink.
If you have any questions or need assistance, please ask. We will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

Name_____ ❑ Male ❑ Female Today's Date _____

Social Security #_____Birthdate_____Home Phone_____

Address_____City_____State_____Zip_____

Mobile Phone_____Email Address _____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Full Time

If Student, Name of School/College_____City_____State_____ ❑ Part Time

Patient's Employer_____Work Phone_____

Business Address_____City _____State_____Zip_____

Spouse or Parent's Name _____Employer_____Work Phone_____

Person to contact in case of emergency _____Phone_____

Emergency contact's relationship to patient _____

Whom may we thank for referring you?_____

INSURANCE INFORMATION

Answer all questions for the person who holds the insurance policy

Name of Insured_____Relationship to Patient _____

Birthdate_____SSN#_____Employee ID_____

Name of Employer_____Work Phone _____

Employer Address_____City _____State_____Zip_____

Insurance Company _____Group #_____Policy/ID#_____

Insurance Company Address_____City _____State_____Zip_____

Over Please

PATIENT MEDICAL HISTORY

Today's Date:_____

Who is your present physician? _____

Office Location _____Phone_____Date of Last Exam_____

	YES	NO	Don't Know
Active Tuberculosis	❑	❑	❑
Perisitant Cough (more than 3 weeks duration)	❑	❑	❑
Cough that produces blood	❑	❑	❑
Scarlet Fever	❑	❑	❑
Rheumatic Fever	❑	❑	❑
Heart Disease	❑	❑	❑
Prosthetic Joint	❑	❑	❑
Mitral Valve Prolapse	❑	❑	❑
Heart Murmur	❑	❑	❑
Anemia	❑	❑	❑
Asthma	❑	❑	❑
Epilepsy	❑	❑	❑

	YES	NO	Don't Know
Mouth Ulcers	❑	❑	❑
Fever Blisters	❑	❑	❑
Migraine Headaches	❑	❑	❑
Diabetes	❑	❑	❑
Cancer	❑	❑	❑
Radiation Therapy	❑	❑	❑
Chemotherapy	❑	❑	❑
Dry Mouth	❑	❑	❑
Sjogren's Syndrome	❑	❑	❑
Blood or Plasma Transfusion	❑	❑	❑
High Blood Pressure	❑	❑	❑
Low Blood Pressure	❑	❑	❑

	YES	NO	Don't Know
AIDS or HIV+	❑	❑	❑
Lupus	❑	❑	❑
Stroke	❑	❑	❑
Hepatitis, Jaundice, or Liver Disease	❑	❑	❑
Heartburn, Ulcer, Sour Stomach, GERD	❑	❑	❑
Kidney Disease	❑	❑	❑
Thyroid Disease	❑	❑	❑
Bleeding Tendency	❑	❑	❑
Arthritis	❑	❑	❑

Any other disease or condition (please list):

_____

	YES	NO
Are you under medical treatment now?	❑	❑

If yes, what conditions are being treated _____

_____

	YES	NO
Have you been hospitalized for any surgical operation or serious illness within the past 5 years?	❑	❑

If yes, please explain _____

_____

	YES	NO
Are you taking any medication(s) including non-prescription medicine? Please list:	❑	❑

Name of Medication	Condition Targeted
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you taking, or have you taken, any diet drugs (e.g. Pondimin, Redux, Phen-fen, or Ephedra)?	❑	❑
Do you use a tobacco product?	❑	❑
Do you use E-Cigarettes?	❑	❑
Recreational drug user?	❑	❑
Have you undergone treatment for drug dependency?	❑	❑

For Women Only:

Are you pregnant or think you may be?	❑	❑
Are you nursing?	❑	❑
Are you taking oral contraceptives?	❑	❑

Are you allergic to or have you had any reactions to the following:	YES	NO
Local Anesthetics (novocaine, etc.)	❑	❑
Penicillin	❑	❑
Other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑
Codeine or other narcotics	❑	❑
Aspirin	❑	❑
Any metals (nickel, mercury, etc.)	❑	❑
Latex (rubber products)	❑	❑

Other _____

If yes, please specify type of reaction:

_____

_____

Do you have a family history of:

Periodontal disease?	❑	❑
Cardiovascular (Heart Attack or Stroke)?	❑	❑
Diabetes?	❑	❑
Arthritis?	❑	❑
Colorectal Cancer?	❑	❑

GENERAL HEALTH

Today's Date:_____

	YES	NO
Do you try to practice good nutrition?	❑	❑
Would you like to learn about proper nutrition for your health?	❑	❑
Do you have a routine exercise practice?	❑	❑
Would you like to learn about the benefits of exercise?	❑	❑

	YES	NO
Do you have trouble sleeping?	❑	❑
Do you snore or wake yourself up from snoring?	❑	❑
Have you had a sleep study?	❑	❑

_____

_____

DENTAL QUESTIONS / HISTORY

What concerns you most about your teeth / smile?_____

_____

Are you completely happy with the appearance of your teeth?_____

Do you have discomfort in any part of the mouth or in any tooth while biting or chewing? _____

_____

Do you have any pain in your teeth because of heat, cold, or sweets? _____

Does food catch between your teeth? If so, where?_____

Do your gums ever bleed or feel tender and swollen? _____

Have you ever been informed about having periodontal disease?_____

How often do you have hygiene visits? _____

We currently have treatments for halitosis / bad breath. Is this something you might be interested in? _____

Do you ever have pain from the jaw joint or jaw muscles?_____

_____

Do you clench or grind your teeth during the day or night?_____

_____

Does your jaw joint ever pop or click?_____

Do you have frequent headaches, earaches, or neck pains? _____

_____

ADULT SLEEP SCREENING QUESTIONNAIRE

Today's Date:_____

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations?
Scale: 0 = Never 1 = Slight chance 2 = Moderate chance 3 = High chance
Sitting and reading _____
Watching TV _____
Sitting inactive in a public place such as theater or meeting _____
Lying down in the afternoon when circumstances permit _____
Sitting and talking to someone_____
Sitting quietly after lunch _____
In a car, stopped in traffic _____
TOTAL _____

Snoring has a significant effect on the quality of sleep and life for many people. Snoring affects the person snoring as well as those around him/her, both physically and emotionally.

Use the following scale to choose the most appropriate number for each situation. (If you sleep alone, proceed to #4)
Scale: 0 = Never 1 = Not Frequent (1 night/week) 2 = Frequently (2-3 nights/week)
3 = Most of the time (4 + nights/week)

1. My snoring affects my relationship with my partner ____
2. My snoring causes my partner to be tired/irritable ____
3. My snoring requires us to sleep in separate rooms ____
4. My snoring is loud ____
5. My snoring affects people when I am sleeping away from home ____

	YES	NO
Have you ever been told you stop breathing while asleep?	❑	❑
Have you ever fallen asleep/nodded off while driving?	❑	❑
Have you ever woken up suddenly with shortness of breath, gasping, or your heart racing?	❑	❑
Do you feel excessively sleepy during the day?	❑	❑
Have you had weight gain and found it difficult to lose?	❑	❑
Do you take medication for or been diagnosed with high blood pressure?	❑	❑
Do you kick or jerk your legs during sleep?	❑	❑
Do you feel tingling, burning or crawling sensations in your legs when you wake up?	❑	❑
Do you wake up with headaches during the night or in the morning?	❑	❑
Do you have trouble falling asleep? It takes me _____ minutes to fall asleep	❑	❑
Do you have trouble staying asleep once you fall asleep? I wake up _____ times per night.	❑	❑
Have genetic family members been diagnosed/treated for sleep apnea?	❑	❑

Do you consume alcohol within 2-3 hours of bedtime? ___ Daily ___ Occasionally ___ Rarely/Never
Do you take sedatives within 2-3 hours of bedtime? ___ Daily ___ Occasionally ___ Rarely/Never

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such health care to third party payors and/or health practitioners.

Signature of Patient (or parent if minor)_____***Date***_____