WINTER

winterdds.net

1401 Avocado Ave.
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CA 92660

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# REGISTRATION & TREATMENT

Welcome to the practice! In order to provide thorough and effective treatment we request you fill out the information below. The medical history section is designed for your safety, and your complete answers will assist us in providing you with the best possible care.

## Patient Information

☐Dr. ☐ Mr. ☐Ms. ☐ Miss ☐ Mrs. Name:_____
Last First MI

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____ Cell:_____

Email:_____ ☐ Married ☐ Single ☐ Divorced ☐ Separated

Spouses/ SO Name:_____

Sex: ☐Male ☐ Female Age:_____ Birth date:_____ Social Security #:_____

Patient Employer:_____ Occupation:_____

Business Address:_____ Business Phone: _____

Dental Insurance:_____ Insured:_____

Insured's SS#:_____ Insured's Birth date: _____

Insured's Employer and Address:_____

Group #:_____ ID#:_____

Referred By:_____ General Dentist:_____

Emergency contact:_____ Phone: _____

Family Physician:_____ Specialty:_____ Date of Last Visit:_____

*Payment is due in full at the time services are rendered unless prior arrangements have been made. We will assist you in submitting insurance forms with payment made directly to the patient or guardian.

## Dental Treatment Information

1. What are the chief complaints for which you are seeking treatment?
   A._____
   B._____
   C._____
2. List treatments you have had for this problem, the date of treatment, and all professionals who have provided care (Specify when partials, crowns and dentures were made and by whom):
   A._____
   B. _____
   C. _____
   D. _____
3. Please rate the following in the order of importance (1 – Very Important, 2- Somewhat Important, 3 – Not Important):
   ____ Comfort ____ Appearance ____ Function
4. What is the date of your last dental exam: _____ By:_____
5. What is the date of your last cleaning:_____
6. How often do you brush your teeth: Floss:

**Have you had any of the following?**

**Mouth**

- ☐ Bleeding, sore gums
- ☐ Unpleasant taste/bad breath
- ☐ Burning tongue/lips
- ☐ Frequent blisters on the tongue/lips
- ☐ Swelling/lumps in mouth
- ☐ Clicking/popping in jaw
- ☐ Difficulty open/closing jaw

**Teeth**

- ☐ Loose teeth
- ☐ Sensitive to heat
- ☐ Sensitive to cold
- ☐ Sensitive to sweets
- ☐ Sensitive to biting
- ☐ Food impaction
- ☐ Clenching/grinding

**Other**

- ☐ Pain or swelling in your jaw joint (TMJ)
- ☐ History of periodontal disease
- ☐ Nervousness during dental treatment
- ☐ Orthodontics (braces)

## Medical History

1. Are you currently taking any medications (include any over the counter medications, vitamins, or other supplements) ☐ No ☐ Yes

   If yes, list_____

2. List any allergic reaction : ☐ None ☐ Latex ☐ Local or General Anesthesia ☐ Medication ☐ Other

   List allergy (s):_____

   Please describe the reaction (hives, difficulty breathing, etc.):_____

3. Recreational drugs such as cocaine, marijuana, stimulants or depressants, may have a fatal interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor.

   _____

**Please read the following list carefully. If you have any of the following, please check or indicate the problem, disorder, or disease on the pink page of this form.**

- ☐ Cardiovascular (heart/circulatory) problems or diseases
- ☐ Respiratory problems or diseases
- ☐ Endocrine (hormonal) disorders or diseases
- ☐ Kidney or liver disorders
- ☐ Musculoskeletal (bone or joint) disorders or problems
- ☐ Mental health issues or problems including eating disorders
- ☐ Need pre-medication for dental work
- ☐ Neurological problems or diseases
- ☐ Blood conditions or positive HIV status
- ☐ Intestinal or stomach conditions
- ☐ Glaucoma or vision problems
- ☐ Cancer or Tumor growth
- ☐ Artificial implants
- ☐ Pregnant or possibly pregnant
- ☐ Medically prescribed diet – Please explain:_____
- ☐ Been hospitalized for a serious injury or illness in the past 5 years - Please explain:_____
- ☐ Any other medical problem or condition of which you need to inform the doctor?

  Please list: _____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at the time of my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is given for the dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility for all treatment provided.

Signature:_____ Date:_____

If patient is under 18 or has been declared incompetent:

Parent/Guardian Signature:_____ Date:_____

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Relationship:_____

**Cardiovascular**

☐ Heart Attack – Date:_____ ☐ Pacemaker ☐ Prosthetic heart valve
☐ Angioplasty – Date:_____ ☐ Stint Placement – Date:_____
☐ Heart Murmur ☐ Swelling in Ankles ☐ Shortness of Breath ☐ Dizziness
☐ Angina (chest pain) - Frequency:_____ ☐ Stroke – Date:_____
☐ High Blood Pressure ☐ Low Blood Pressure ☐ CHF ☐ Peripheral Vascular Disease
☐ Blood Clots ☐ Heart Surgery – Type and date:_____
Other:_____

**Respiratory**

☐ Asthma ☐ Chronic Obstructive Pulmonary Disease ☐ Emphysema
☐ Chronic Cough ☐ TB – date(s) treated:_____
Tobacco: ____ packs per day for approximately _____ years. Quit smoking _____ years ago.

**Endocrine**

☐ Diabetes – Treated by: ☐ Diet ☐ Oral Agent ☐ Insulin
☐ Thyroid Disease ☐ Parathyroid Disease ☐ Hypoglycemia
Other:_____

**Kidney or Liver**

☐ Hepatitis - ☐ A (Food) ☐ B (Blood) ☐ C
☐ Jaundice ☐ Urinary pain ☐ Urinary frequency ☐ Kidney stones
Other:_____

**Bone or Joint**

☐ Arthritis - ☐ Rheumatoid ☐ Osteoarthritis ☐ Osteoporosis
☐ Chronic back, neck or head pain ☐ Joint Replacements
If caused by any type of trauma, please explain:_____
Other:_____

**Neurological**

☐ Convulsions ☐ Fainting spells ☐ Migraines ☐ Frequent headaches
☐ Numbness in arms or legs ☐ Parkinson's Disease
Other:_____

**Blood Conditions or Diseases**

☐ Excessive bleeding or bruising ☐ HIV Positive ☐ AIDS ☐ Leukemia
☐ Anemia ☐ Venereal Disease ☐ Sickle Cell ☐ Von Willebrands
☐ Hemophilia Other:_____

**Intestinal or Stomach**

☐ Ulcers ☐ Diverticulitis ☐ Crohn's Disease ☐ Irritable Bowel Syndrome
☐ Diarrhea ☐ Chronic Constipation ☐ Other:_____

**Vision**

☐ Blind ___ Right Eye ___ Left Eye ☐ Glaucoma ☐ Diplopia
☐ Other:_____

**Mental Health**

☐ Bulimia ☐ Anorexia ☐ Depression ☐ Bi-polar Disease ☐ Schizophrenia
☐ Other:_____

**Name of Physician Providing Care:**
_____

**City:**_____

**Phone Number:**_____