AMELIA ISLAND DENTAL
REGISTRATION AND HISTORY

PATIENT INFORMATION

Name: _____ SS#: _____ Date: _____

Address: _____ Phone: _____

_____

Cell phone: _____ Sex: **M F** Age: _____ Birth date: _____

Employer: _____ Occupation: _____

Phone: _____ Fax: _____

Spouse or Parent (**If Patient is a minor**.) Name: _____ Birth date: _____

Employer: _____ Occupation: _____

Email Address: _____

***** Whom may we thank for referring you? _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

Address: _____ Work Phone: _____

_____ Cell # _____

DENTAL INSURANCE INFORMATON

Insurance Co. _____ Group # _____

Subscriber's Name: _____ SSN: _____ Birth date: _____

We are pleased that you have dental insurance and will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company. As a courtesy to you, we will file your primary insurance; however, not all services are a covered benefit in all contracts, insurance companies and employers select the services they are willing to cover.

DENTAL HISTORY

Reason for today's visit: _____

Former Dentist _____ **Phone #** _____ **Date of last visit** _____

Dates of last: X-rays _____ Periodontal Exam _____ Oral Cancer Exam _____

Please circle **Y** for **Yes** or **N** for **No** to the following questions.

Y N Bad breath	**Y N** Bleeding gums
Y N Blisters on lips or mouth	**Y N** Broken fillings? How many
Y N Dry mouth	**Y N** Chew on one side of mouth
Y N Jaw clicking or popping	**Y N** Tobacco Use? What type
Y N Food collection between teeth	**Y N** Fingernail biting
Y N Grinding teeth	**Y N** Foreign Objects Usage
Y N Jaw pain or tiredness	**Y N** Gums swollen or tender
Y N Loose teeth	**Y N** Lip or cheek biting
Y N Pain with brushing	**Y N** Mouth breathing
Y N Pain around ears	**Y N** Orthodontic treatment
Y N Sensitivity to cold/ sweets	**Y N** Periodontal treatment
Y N Sores or growths in your mouth	**Y N** Sensitivity to heat
Y N Do you use a fluoride rinse?	**Y N** Sensitivity when biting
Y N Do you plan to keep your own teeth for life?	**Y N** Do you use an electric toothbrush?

Please answer the following questions

What do you rinse with?	What brand of toothpaste do you use?
How often do you floss?	How often do you brush?

ALLERGIES

Y N Aspirin	**Y N** Barbiturates/sleeping pills	**Y N** Codeine
Y N Iodine	**Y N** Latex	**Y N** Local Anesthetic
Y N Penicillin	**Y N** Sulfa	**Y N** Food allergies
Y N Others		

MEDICAL HISTORY

Physician's Name _____ **Phone** _____ **Last Visit** _____

Alternative Health Care Providers _____

Have you had or do you have any of the following medical conditions? Please circle **Y** for **YES** or **N** for **NO**.

Y N Asthma	**Y N** Anemia	**Y N** Arthritis, Rheumatism
Y N Artificial Heart Valves	**Y N** Artificial Joints	**Y N** HIV/AIDS
Y N Back problems	**Y N** Blood disorder/disease	**Y N** Cancer
Y N Chemical dependency	**Y N** Chemotherapy	**Y N** Circulatory problems
Y N Congenital heart lesions	**Y N** Cortisone treatment	**Y N** Cough, persistent or bloody
Y N Diabetes	**Y N** Emphysema	**Y N** Glaucoma
Y N Epilepsy	**Y N** Fainting or dizziness	**Y N** Heart problems

Y N Headaches	**Y N** Heart murmur	**Y N** High blood pressure
Y N Hepatitis Type? A B C	**Y N** Herpes	**Y N** Jaw pain
Y N Kidney disease	**Y N** Jaundice	**Y N** Low blood pressure
Y N Mitral valve prolapse	**Y N** Liver disease	**Y N** Pacemaker
Y N Pregnant	**Y N** Nervous problems	**Y N** Psychiatric care
Y N Radiation treatment	**Y N** Lactating/nursing	**Y N** Rheumatic fever
Y N Scarlet fever	**Y N** Respiratory disease	**Y N** Sinus trouble
Y N Skin rash	**Y N** Shortness of breath	**Y N** Stroke
Y N Swelling of feet or ankles	**Y N** Special diet	**Y N** Thyroid problems
Y N Tonsillitis	**Y N** Swollen neck gland	**Y N** Ulcer
Y N Venereal disease	**Y N** Tuberculosis	**Y N** Anxiety
Y N Abnormal bleeding	**Y N** Unexplained weight loss?	**Y N** Tumor/ growth on head/neck
Y N Are you being treated for OSTEOPOROSIS? Name of Medication?		

Y N Have you ever been told by a Physician that you need to be PRE-MEDICATED prior to dental

MEDICATIONS

Please list all prescriptions, vitamins, supplements, and herbals you are taking and the dosage.

_____

_____

_____

DOCTOR'S NOTES

_____

_____

_____

*** Patient Signature** _____ Date _____

Vital Signs: **B/P** _____ **HR** _____ _____

Dr. Signature _____ Date _____