

# PATIENT REGISTRATION

Joel J. Piehl D.D.S. Inc.

Patient's Name \_\_\_\_\_ Single   
 Name of Spouse \_\_\_\_\_ Widowed   
 If a Child, Parent's Name \_\_\_\_\_ Married   
 \_\_\_\_\_ Divorced   
 \_\_\_\_\_ Separated   
 Street Address \_\_\_\_\_ Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Patient Employed by \_\_\_\_\_ Phone \_\_\_\_\_  
 Business Address \_\_\_\_\_ Email: \_\_\_\_\_  
 Present Position \_\_\_\_\_ How Long Held \_\_\_\_\_  
 Spouse Employed by \_\_\_\_\_ Phone \_\_\_\_\_  
 Business Address \_\_\_\_\_  
 Present Position \_\_\_\_\_ How Long Held \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ C.A. Drivers Lic# \_\_\_\_\_ Spouse S.S. # \_\_\_\_\_  
 In Case of Emergency, Who Should be Notified \_\_\_\_\_ Phone \_\_\_\_\_  
 If You Have Insurance, Name of Insured \_\_\_\_\_  
 Name of Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_  
 Is Policy Connected with a Union Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, Name of Union \_\_\_\_\_  
 Local No. \_\_\_\_\_ Group No. \_\_\_\_\_  
 Who May We Thank for Referring You \_\_\_\_\_

# HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Purpose of this Appointment \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Please answer each question. Check yes or no. If in doubt, leave blank.

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Are you in good health now? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you now under the care of a physician? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, what is the condition being treated? _____  |                          |                          |
| 3. Have you ever been hospitalized or had a serious illness? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain _____  |                          |                          |
| 4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. (Women) Are you pregnant? If so, give due date _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use tobacco in any form? If yes, how much _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use alcoholic beverages (more than 2 drinks per day)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have or have you ever had any of the following?  |                          |                          |

### GENERAL

- |                             | YES                      | NO                       |
|-----------------------------|--------------------------|--------------------------|
| Tire easily, weakness ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Marked weight change .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweats .....          | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent fever .....      | <input type="checkbox"/> | <input type="checkbox"/> |

### SKIN

- |                              |                          |                          |
|------------------------------|--------------------------|--------------------------|
| Eruptions (rash) hives ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in skin color .....   | <input type="checkbox"/> | <input type="checkbox"/> |

### EYES

- |                     |                          |                          |
|---------------------|--------------------------|--------------------------|
| Visual change ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma .....      | <input type="checkbox"/> | <input type="checkbox"/> |

### EARS

- |                       |                          |                          |
|-----------------------|--------------------------|--------------------------|
| Loss of hearing ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringing in ears ..... | <input type="checkbox"/> | <input type="checkbox"/> |

### NOSE

- |                           |                          |                          |
|---------------------------|--------------------------|--------------------------|
| Frequent nosebleeds ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems .....      | <input type="checkbox"/> | <input type="checkbox"/> |

### DIGESTIVE SYSTEM

- |                                    |                          |                          |
|------------------------------------|--------------------------|--------------------------|
| Hepatitis .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaundice .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in appetite .....           | <input type="checkbox"/> | <input type="checkbox"/> |
| Black, bloody or pale stools ..... | <input type="checkbox"/> | <input type="checkbox"/> |

### URINARY

- |  |                          |                          |
|--|--------------------------|--------------------------|
| Kidney disease .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Increase in frequency of urination (night) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning on urination .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Urethral discharge .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloody urine .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Venereal disease .....                           | <input type="checkbox"/> | <input type="checkbox"/> |

### BLOOD

- |                         |                          |                          |
|-------------------------|--------------------------|--------------------------|
| Bruise easily .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood transfusion ..... | <input type="checkbox"/> | <input type="checkbox"/> |

### HEART/BLOOD VESSELS

- |                                | YES                      | NO                       |
|--------------------------------|--------------------------|--------------------------|
| Rheumatic fever .....          | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain/discomfort .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack/trouble .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath .....      | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling of ankles .....       | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure .....      | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital heart disease ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial heart valve .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart surgery .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____                    |                          |                          |

### BONE/MUSCLES

- |                            |                          |                          |
|----------------------------|--------------------------|--------------------------|
| Arthritis/rheumatism ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial joints .....    | <input type="checkbox"/> | <input type="checkbox"/> |

**THROAT**

- Soreness/hoarseness
- NERVOUS SYSTEM**
- Stroke
- Headaches
- Convulsions/epilepsy
- Numbness/tingling
- Dizziness/fainting
- Psychiatric treatment

**RESPIRATORY**

- Tuberculosis
- Emphysema
- Asthma/hay fever
- Persistent cough
- Sputum production (phlegm)
- Cough up bloody sputum
- Difficulty breathing while lying down

**ENDOCRINE**

- Diabetes
- Family history of diabetes
- Thyroid condition/goiter
- Other \_\_\_\_\_
- OTHER**
- Radiation therapy
- Tumors or growths
- Cancer
- HIV

9. Are you ALLERGIC or have you ever experienced any reaction to the following?

- |                                       | YES                      | NO                       |
|---------------------------------------|--------------------------|--------------------------|
| Local anesthetics (e.g. novocaine)    | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates/sedatives/sleeping pills | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin/other antibiotics          | <input type="checkbox"/> | <input type="checkbox"/> |

- |                    | YES                      | NO                       |
|--------------------|--------------------------|--------------------------|
| Aspirin or Codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs        | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex Gloves       | <input type="checkbox"/> | <input type="checkbox"/> |
| Phenphen           | <input type="checkbox"/> | <input type="checkbox"/> |

Other Allergies \_\_\_\_\_

10. Are you taking any of the following?

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| Antibiotics/sulfa drugs                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood thinners                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure medication                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid medicine                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Cortisone/steroids                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Antihistamines/allergy drugs/<br>cold remedies | <input type="checkbox"/> | <input type="checkbox"/> |

- |                                  | YES                      | NO                       |
|----------------------------------|--------------------------|--------------------------|
| Tranquillizers                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Insulin/other diabetes drugs     | <input type="checkbox"/> | <input type="checkbox"/> |
| Recreational drugs               | <input type="checkbox"/> | <input type="checkbox"/> |
| Digitals/other heart medications | <input type="checkbox"/> | <input type="checkbox"/> |
| Nitroglycerin                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Other medication _____           |                          |                          |

If yes to any of the above, list name of medication and dosage below:

\_\_\_\_\_

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain \_\_\_\_\_

12. Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

13. Have you ever had any serious trouble associated with previous dental treatment? \_\_\_\_\_

14. Does dental treatment make you nervous? No \_\_\_\_\_ Slightly \_\_\_\_\_ Moderately \_\_\_\_\_ Extremely \_\_\_\_\_

15. Date of last dental visit \_\_\_\_\_

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? \_\_\_\_\_  
If so, when? \_\_\_\_\_

17. Do you have or have you ever had any of the following?

**MOUTH**

- |                                   | YES                      | NO                       |
|-----------------------------------|--------------------------|--------------------------|
| Bleeding, sore gums               | <input type="checkbox"/> | <input type="checkbox"/> |
| Unpleasant taste/bad breath       | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning tongue/lips               | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent blisters, lips/mouth     | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling/lumps in mouth           | <input type="checkbox"/> | <input type="checkbox"/> |
| Ortho treatments (braces)         | <input type="checkbox"/> | <input type="checkbox"/> |
| Biting cheeks/lips                | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking/popping jaw              | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty opening or closing jaw | <input type="checkbox"/> | <input type="checkbox"/> |

**TEETH**

- |                     | YES                      | NO                       |
|---------------------|--------------------------|--------------------------|
| Loose teeth         | <input type="checkbox"/> | <input type="checkbox"/> |
| Sensitive to hot    | <input type="checkbox"/> | <input type="checkbox"/> |
| Sensitive to cold   | <input type="checkbox"/> | <input type="checkbox"/> |
| Sensitive to sweets | <input type="checkbox"/> | <input type="checkbox"/> |
| Sensitive to biting | <input type="checkbox"/> | <input type="checkbox"/> |
| Food impaction      | <input type="checkbox"/> | <input type="checkbox"/> |
| Clenching/grinding  | <input type="checkbox"/> | <input type="checkbox"/> |
| Shifting of teeth   | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in bite      | <input type="checkbox"/> | <input type="checkbox"/> |

**ORAL HYGIENE**

- | Do you use the following? | YES                      | NO                       |
|---------------------------|--------------------------|--------------------------|
| Brush                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental floss              | <input type="checkbox"/> | <input type="checkbox"/> |
| Fluoride rinse            | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____               |                          |                          |

How often do you brush \_\_\_\_\_  
Brush is: Soft  Medium  Hard

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient  
Parent, or Guardian \_\_\_\_\_

Date \_\_\_\_\_