ADVANCED AESTHETIC DENTISTRY

MARC SCLAFANI, D.D.S, P.C.

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Patient Registration and Health History

Please fill out all three pages of this form completely, so that we can correctly process your account information. Thank you!

__/__/___
Date

(Last Name) (First Name You Use) (Middle Initial) (Legal First Name If Different)

Billing Address (Street) (Apt.) (City) (State) (Zip Code)

(Home Phone)

(Work Phone)

(Cell Phone)

(E-Mail Address)

___/___/___
Date of Birth

Sex M ( ) F ( )

Marital Status Single( ) Married( ) Name of spouse_____ Divorced( ) Widowed( )

_____/_____/_____
Social Security Number

Person Responsible for Account (Street) (City) (State) (Zip Code) (Telephone)
(If Other Than Self)

_____
Referred By

Medical History

Do you have a personal physician? Yes( ) No( )

Physician's Name:_____

Phone #( )_____ Date of last visit_____

Your current physical health is: ----------Good ( ) Fair ( ) Poor ( )
Are you currently under care for a specific condition? ----------Yes ( ) No ( )
Please explain:_____

Have you ever had any of the following diseases or medical conditions?

Y N Abnormal Bleeding
Y N Anemia
Y N Asthma
Y N Diabetes
Y N Epilepsy
Y N Heart Murmur
Y N Hepatitis
Y N Herpes/ Fever Blisters
Y N HIV/ AIDS
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Radiation Treatment
Y N Rheumatic/ Scarlet Fever
Y N Sickle Cell History
Y N Tuberculosis (TB)
Y N Reconstructive Surgery

Y N Allergies
Y N Ulcers
Y N Shingles
Y N Arthritis
Y N Sinus Problems
Y N Heart Surgery
Y N Cancer/ Chemotherapy
Y N Headaches/ TMJ
Y N High Blood Pressure
Y N Artificial Bones/ Joints/ Valves
Y N Cough
Y N Blood Transfusion
Y N Hospitalization for any reason
Y N Kidney Problems
Y N Low Blood Pressure

Please list any serious medical condition(s) that you have ever had:

DO YOU NEED TO PREMEDICATE FOR DENTAL VISITS? Y N

Are you taking any prescription drugs?---------- Yes ( ) No ( )
If yes, please list:
_____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs that you are all**ergic** to:_____

_____

For Women:
Are you taking birth control pills?----------Yes ( ) No ( )
Are you pregnant?---------- Yes ( ) No ( )
Are you nursing? ---------- Yes ( ) No ( )

Dental History

Why have you come to the office today?_____

_____

Are you currently in pain? ( ) Yes ( ) No
Have you ever had a serious / difficult problem associated with dental treatment ? ( ) Yes ( ) No
Have you ever had gum treatment? ( ) Yes ( ) No

Do you now or have you ever experienced pain / discomfort in your jaw joint? (TMJ)? ( ) Yes ( ) No

Your current dental health is: ( ) Excellent ( ) Good ( ) Fair ( ) Poor
Do your gums ever bleed? ( ) Yes ( ) No
How many times a week do you floss?_____ a day do you brush?_____
Type of bristles? ( ) Soft ( ) Medium ( ) Hard
How long do you use a toothbrush before replacing it?_____
Are your teeth sensitive to hot, cold, or anything else?
_____

Have you lost any teeth? ( ) Yes ( ) No If yes, why?_____

Office Financial Policy

Payment is patient responsibility and is due in full at the time of service unless prior arrangements have been made.

Must Sign Below

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature Date