



# BEST CHOICE

## DENTAL IMPLANT CENTER

KNOWLEDGE • EXPERIENCE • TECHNOLOGY • LABORATORY

### PATIENT REGISTRATION

Ms. Mr.  
Miss Dr.  
Please Print Name: Mrs. \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (MI)

By What Name Do You Prefer To Be Addressed: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Message #: \_\_\_\_\_  
Telephone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex M \_\_\_ F \_\_\_ Single \_\_\_ Married \_\_\_ Div. \_\_\_ Widowed \_\_\_

Employer or Name of Business: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Ext.: \_\_\_\_\_

Occupation: \_\_\_\_\_

### PERSON RESPONSIBLE FOR ACCOUNT

Check If Same As Above.

Name: \_\_\_\_\_  
(Last) (First) (MI) (Date of Birth)

Address (if different from above): \_\_\_\_\_ Apt. #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Employer or Name of Business: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Ext. #: \_\_\_\_\_

Occupation: \_\_\_\_\_

### NOTIFY IN CASE OF EMERGENCY (not residing with you)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(Last) (First) (MI)

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Message #: \_\_\_\_\_  
Telephone #: \_\_\_\_\_

### REFERRAL INFORMATION

How did you first hear about our office? \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_





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### DENTAL HISTORY

—Continued—

How Many Times Have Your Dentures Been Relined?	Upper _____	Lower _____
How Long Have You Worn Dentures?	Upper _____	Lower _____
How Old Are Your Current Dentures?	Upper _____	Lower _____
How Many Dentures Have You Had?	Upper _____	Lower _____
What Do You Think is Wrong with Your Dentures? _____		
_____		
What Comments Have Friends Or Family Made About Your Teeth? _____		
_____		
What Do You Think Dentures Should Do For You? Number in Order of Importance to You: 1 (Most Important) – 6 (Least Important)		
_____ Improve Chewing	_____ Improve Appearance	
_____ Improve Comfort	_____ Remove Facial Lines/Wrinkles	
_____ Improve Speech	_____ Fit Well	

Please Add Anything You Feel Is Important: _____
_____
_____
Comments (For Doctors Use): _____
_____
_____
_____
_____
_____
_____

*Thank you for completing this detailed questionnaire. The information gained from this form will allow us to determine an accurate diagnosis, and develop an individualized treatment plan that will ensure you receive safe, quality care.*

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### MEDICAL HISTORY

Please Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (MI) (Date of Birth)

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

#### PURPOSE

*Although this is a detailed questionnaire it is imperative that we have this information. It is designed to identify medical problems of which you may or may not be aware, and which can have significant impact on the delivery of safe, effective dental care.*

*This information is confidential, and will only be shared with medical/dental providers involved in your care and that you authorize.*

Please check any of the following illnesses or conditions you now have or have had in the past:

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Congenital Heart Defect   | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Bulimia/Anorexia       | <input type="checkbox"/> Frequent Fainting      |
| <input type="checkbox"/> Heart Infection           | <input type="checkbox"/> Cough Up Blood        | <input type="checkbox"/> Frequent Regurgitation | <input type="checkbox"/> Daytime Sleepiness     |
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Frequent Vomiting      | <input type="checkbox"/> Artificial Joints      |
| <input type="checkbox"/> Low Blood Pressure        | <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Hepatitis A, B or C    | <input type="checkbox"/> Painful/Swollen Joints |
| <input type="checkbox"/> Heart Attack              | <input type="checkbox"/> Lung Problems         | <input type="checkbox"/> Cirrhosis              | <input type="checkbox"/> Arthritis              |
| Date: _____  | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Stroke                    | <input type="checkbox"/> Persistent Cough      | <input type="checkbox"/> Liver Disease          | Type: _____                                     |
| Date: _____  | <input type="checkbox"/> Hives, Rash           | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Radiation Therapy      |
| <input type="checkbox"/> Cardiac Pacemaker         | <input type="checkbox"/> Allergy To:           | <input type="checkbox"/> Frequent Urination     | Location: _____                                 |
| <input type="checkbox"/> Artificial Heart Valves   | <input type="checkbox"/> Latex (rubber)        | <input type="checkbox"/> (more than 6x/day)     | <input type="checkbox"/> Tumor                  |
| <input type="checkbox"/> Angina (chest pain)       | <input type="checkbox"/> Penicillin            | <input type="checkbox"/> Excessive Thirst       | <input type="checkbox"/> Chemotherapy           |
| <input type="checkbox"/> Congestive Heart Failure  | <input type="checkbox"/> Erythromycin          | <input type="checkbox"/> Thyroid Problems       | <input type="checkbox"/> Blood Transfusion      |
| <input type="checkbox"/> Hardening of Arteries     | <input type="checkbox"/> Other Antibiotics     | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Organ Transplant       |
| <input type="checkbox"/> Shortness of Breath       | <input type="checkbox"/> Aspirin               | <input type="checkbox"/> Convulsions/Seizures   | <input type="checkbox"/> Excessively Nervous    |
| <input type="checkbox"/> Ankles Swell              | <input type="checkbox"/> Codeine               | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Nervous Breakdown      |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Dental Anesthetics    | <input type="checkbox"/> Multiple Sclerosis     | <input type="checkbox"/> Venereal Disease       |
| <input type="checkbox"/> Prolonged Bleeding        | <input type="checkbox"/> Metal                 | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Swollen Glands         |
| <input type="checkbox"/> HIV+, AIDS, ARC           | <input type="checkbox"/> Denture Plastic       | <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Used Steroids in Last  |
| <input type="checkbox"/> Blood Disorders           | <input type="checkbox"/> Other                 | <input type="checkbox"/> Eye Problems           | 6 months  |
| <input type="checkbox"/> Use Blood Thinners        | <input type="checkbox"/> 'Stuffy' Ears         | <input type="checkbox"/> Sinus Problems         | <input type="checkbox"/> Used Cortisone in      |
| <input type="checkbox"/> Hemophilia                | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Difficulty Swallowing  | Last 6 months                                   |
| <input type="checkbox"/> Leukemia                  | <input type="checkbox"/> Stomach Ulcers        | <input type="checkbox"/> Snoring                | <input type="checkbox"/> Smoker                 |
| <input type="checkbox"/> Blood Disorders           | <input type="checkbox"/> Recreational Drug Use |   | Packs/day: _____                                |
| <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> Alcohol Dependent     | <input type="checkbox"/> Osteoporosis           | Years: _____                                    |
| <input type="checkbox"/> Frequent Infections       | <input type="checkbox"/> Use Cocaine*          |   |   |
| <input type="checkbox"/> Compromised Immune System |  |   |   |

\*ADMINISTRATION OF A DENTAL ANESTHETIC TO A COCAINE USER CAN BE FATAL]



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Have you been examined by a physician within the last year?..... YES NO

Date of Last physical examination \_\_\_\_\_

**Have you been under a physician's care within the last year?**..... YES NO

For what condition? \_\_\_\_\_

Have you noticed any change in your health in the past year?..... YES NO

**Have you ever had a reaction to "Novocain" or other dental anesthetics?**..... YES NO

Do you have any medical condition that should be brought to the doctors attention?..... YES NO

Are you taking any medication for osteoporosis such as Boniva, Fosomax, Actonel, Zometa?.. YES NO

WOMEN ONLY:

Are you pregnant at this time, or taking birth control? .....YES NO

LIST MEDICATIONS, VITAMINS, NUTRITIONAL or HERBAL SUPPLEMENTS YOU ARE CURRENTLY TAKING:

MEDICATION, VITAMINS, SUPPLEMENT:	Reason you are taking this medication, vitamin or suppl.:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____

COMMENTS (For Doctor's Use): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*You may refuse to sign this acknowledgement\*

*I have read and understand this form. Terms with which I may have been unfamiliar have been explained to my satisfaction. I will not hold Dr. Moore or any members of his staff responsible for any errors, or omissions that I may have made in the completion of this form.*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_