ROBERT E. DAY, DDS, FAGD

PATIENT REGISTRATION AND MEDICAL / DENTAL HISTORY

Committed To Excellence... Because We Care"

Tel: 207-236-8891 • www.DrRobertDay.com

So that we may provide you with the best possible care, please complete both sides of this medical/dental history form.

(PLEASE PRINT)

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

Patient Name _____ (Preferred Name _____)

Home Phone _____ Work Phone _____ Cell/Pager _____ Email _____

Address _____

City _____ State _____ Zip _____ Social Security # _____ Driver's Lic.# _____

Sex: ☐ Male ☐ Female Age _____ Birthday ___/___/___ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed By _____

Occupation _____

Business Address _____

City _____ State _____ Zip _____ Tel. _____

Spouse Name _____ Birthday ___/___/___

Employed By _____

Business Address _____

City _____ State _____ Zip _____ Tel. _____

Social Security # _____

Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____

Hm#( ) _____ DL# _____

Employer: _____

Wk#( ) _____ Ext: _____ SS# _____

Dental Insurance Primary Carrier

Insured's Name _____ Social Security # _____

Insurance Company _____ Telephone _____

Address _____

City _____ State _____ Zip _____

Group Number _____ ID Number _____ Birthdate _____

Insured's Employer _____

Dental Insurance Secondary Carrier

Insured's Name _____ Social Security # _____

Insurance Company _____ Telephone _____

Address _____

City _____ State _____ Zip _____

Group Number _____ ID Number _____ Birthdate _____

Insured's Employer _____

DENTAL HISTORY

Circle "Yes" or "No" to each item.

Do you:

- Clench or grind your teeth while awake or asleep? Yes No
- Bite your lips or cheeks regularly? Yes No
- Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No
- Mouth breathe while awake or asleep Yes No
- Have tired jaws, especially in the morning? Yes No
- Smoke/chew tobacco? Yes No
  - How much? _____

Have you ever had:

- Orthodontic treatment? Yes No
- Oral surgery? Yes No
- Periodontal treatment? Yes No
- A bite plate or mouth guard? Yes No
- A serious injury to the mouth or head? Yes No
  - If yes please describe, including cause.

_____

Date of last dental cleaning/exam? _____

Are any of your teeth sensitive to:

- Hot or cold? Yes No
- Sweet? Yes No
- Biting or chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or a change in your bite? Yes No

Do you have difficulty in chewing on either side of the mouth? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? _____

_____

Have you ever experienced:

- Clicking or popping of the jaw? Yes No
- Pain? (joint, ear, side of face) Yes No
- Difficulty in opening or closing the mouth? Yes No
- Headaches, neckaches or shoulder aches? Yes No
- Sore muscles (neck, shoulders)? Yes No

Are you happy with your smile? Yes No

Are you pleased with the color of your teeth? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If yes, what is your biggest concern?

_____

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

_____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Physician Name _____ Phone _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Do you take, or have you taken, Boniva, Actonel or any other medications containing Bisphosphonates? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the folllowing?

AIDS/HIV Positive ◯Yes ◯No	Cortisone Medicine ◯Yes ◯No	Hemophilia ◯Yes ◯No	Recent Weight Loss ◯Yes ◯No
Alzheimer's Disease ◯Yes ◯No	Diabetes ◯Yes ◯No	Hepatitis A ◯Yes ◯No	Renal Dialysis ◯Yes ◯No
Anaphylaxis ◯Yes ◯No	Drug Addiction ◯Yes ◯No	Hepatitis B or C ◯Yes ◯No	Rheumatic Fever ◯Yes ◯No
Anemia ◯Yes ◯No	Easily Winded ◯Yes ◯No	Herpes ◯Yes ◯No	Rheumatism ◯Yes ◯No
Angina ◯Yes ◯No	Emphysema ◯Yes ◯No	High Blood Pressure ◯Yes ◯No	Scarlet Fever ◯Yes ◯No
Arthritis/Gout ◯Yes ◯No	Epilepsy or Seizures ◯Yes ◯No	High Cholestrol ◯Yes ◯No	Shingles ◯Yes ◯No
Artificial Heart Valve ◯Yes ◯No	Excessive Bleeding ◯Yes ◯No	Hives or Rash ◯Yes ◯No	Sickle Cell Disease ◯Yes ◯No
Artificial Joint ◯Yes ◯No	Excessive Thirst ◯Yes ◯No	Hypoglycemia ◯Yes ◯No	Sinus Trouble ◯Yes ◯No
Asthma ◯Yes ◯No	Fainting Spells/Dizziness ◯Yes ◯No	Irregular Heartbeat ◯Yes ◯No	Spina Bifida ◯Yes ◯No
Blood Disease ◯Yes ◯No	Frequent Cough ◯Yes ◯No	Kidney Problems ◯Yes ◯No	Stomach/Intestinal Disease ◯Yes ◯No
Blood Transfusion ◯Yes ◯No	Frequent Diarrhea ◯Yes ◯No	Leukemia ◯Yes ◯No	Stroke ◯Yes ◯No
Breathing Problem ◯Yes ◯No	Frequent Headaches ◯Yes ◯No	Liver Disease ◯Yes ◯No	Swelling of Limbs ◯Yes ◯No
Bruise Easily ◯Yes ◯No	Genital Herpes ◯Yes ◯No	Low Blood Pressure ◯Yes ◯No	Thyroid Disease ◯Yes ◯No
Cancer ◯Yes ◯No	Glaucoma ◯Yes ◯No	Lung Disease ◯Yes ◯No	Tonsillitis ◯Yes ◯No
Chemotherapy ◯Yes ◯No	Hay Fever ◯Yes ◯No	Mitral Valve Prolapse ◯Yes ◯No	Tuberculosis ◯Yes ◯No
Chest Pains ◯Yes ◯No	Heart Attack/Failure ◯Yes ◯No	Osteoporosis ◯Yes ◯No	Tumors or Growths ◯Yes ◯No
Cold Sores/Fever Blisters ◯Yes ◯No	Heart Murmur ◯Yes ◯No	Pain in Jaw Joints ◯Yes ◯No	Ulcers ◯Yes ◯No
Congenital Heart Disorder ◯Yes ◯No	Heart Pacemaker ◯Yes ◯No	Parathyroid Disease ◯Yes ◯No	Venereal Disease ◯Yes ◯No
Convulsions ◯Yes ◯No	Heart Trouble/Disease ◯Yes ◯No	Psychiatric Care ◯Yes ◯No	Yellow Jaundice ◯Yes ◯No
		Radiation Treatments ◯Yes ◯No	

Have you had any joint replacements? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been advised to be pre-medicated prior to any dental procedure? ☐ Yes ☐ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Do you wear contact lenses? ◯ Yes ◯ No

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

If Patient is a child what is his/her weight? _____

Is there anything else we should know about your medical history _____

Comments: _____

_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent if minor)

Doctor's Comments _____