



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.

<p>Do you:</p> <p>Glench or grind your teeth while awake or asleep? Yes No</p> <p>Bite your lips or cheeks regularly? . . . Yes No</p> <p>Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No</p> <p>Mouth breathe while awake or asleep Yes No</p> <p>Have tired jaws, especially in the morning? Yes No</p> <p>Smoke/chew tobacco? Yes No</p> <p>How much? _____</p> <p>Have you ever had:</p> <p>Orthodontic treatment? Yes No</p> <p>Oral surgery? Yes No</p> <p>Periodontal treatment? Yes No</p> <p>A bite plate or mouth guard? Yes No</p> <p>A serious injury to the mouth or head? Yes No</p> <p>If yes please describe, including cause. _____</p>	<p>Are any of your teeth sensitive to:</p> <p>Hot or cold? Yes No</p> <p>Sweet? Yes No</p> <p>Biting or chewing? Yes No</p> <p>Have you noticed any mouth odors or bad tastes? Yes No</p> <p>Do you frequently get cold sores, blisters or any other oral lesions? Yes No</p> <p>Do your gums bleed or hurt? Yes No</p> <p>Have your parents experienced gum disease or tooth loss? Yes No</p> <p>Have you noticed any loose teeth or a change in your bite? Yes No</p> <p>Do you have difficulty in chewing on either side of the mouth? Yes No</p> <p>Does food tend to become caught in between your teeth? Yes No</p> <p>If yes, where? _____</p>	<p>Have you ever experienced:</p> <p>Clicking or popping of the jaw? Yes No</p> <p>Pain? (joint, ear, side of face) Yes No</p> <p>Difficulty in opening or closing the mouth? . Yes No</p> <p>Headches, neckaches or shoulder aches? Yes No</p> <p>Sore muscles (neck, shoulders)? Yes No</p> <p>Are you happy with your smile? Yes No</p> <p>Are you pleased with the color of your teeth? . Yes No</p> <p>Would you like to keep all of your teeth all of your life? Yes No</p> <p>Do you feel nervous about having dental treatment? Yes No</p> <p>If yes, what is your biggest concern? _____</p> <p>_____</p> <p>Have you ever had an upsetting dental experience? Yes No</p> <p>If yes, please describe _____</p>
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Date of last dental cleaning/exam? _____

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 following? _____

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