502-292-3272

OLDHAM COUNTY
family dentistry

oldhamcountyfamilydentistry@gmail.com

PATIENT REGISTRATION

Patient's Name: _____ Preferred Name: _____ Today's Date: _____

Sex: ☐ M ☐ F Birth Date: _____ Age: _____ SSN: _____

Please check one: ☐ Single ☐ Married ☐ Separated ☐ Widow Do you have an advanced medical directive? ☐ Yes ☐ No

Race / Ethnicity: _____ Primary Language: _____ Occupation: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Fax #: _____

Your Employer: _____ How Long Employed: _____

Are you a Full Time Student? *If patient is a minor we need:*

☐ Yes ☐ No Mother's DOB: _____ Father's DOB: _____

Person Responsible for Account: _____ SSN #: _____

Email Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Fax #: _____

Employer: _____

How did you hear about our office?

☐ Personal Referral ☐ Website ☐ Mailings ☐ Social Media ☐ Sign

Name of person referring you to us: _____ Relationship: _____

EMERGENCY INFORMATION

Name, Address & Phone of a relative not living with you: _____

_____

Reason for this visit: _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name: _____

DOB: _____ SSN: _____

Insured's Employer: _____

Insurance Company: _____

Ins. Co. Address: _____

_____

Phone #: _____

Group #: _____ Local #: _____

If you have a double insurance coverage, complete this for the second coverage:

Insured's Name: _____

DOB: _____ SSN: _____

Insured's Employer: _____

Insurance Company: _____

Ins. Co. Address: _____

_____

Phone #: _____

Group #: _____ Local #: _____

PLEASE TURN OVER

DENTAL HISTORY

Please mark any of the following that apply to you:

☐ Sensitivity (hot, cold, sweets, pressure) ☐ Discomfort when chewing ☐ Headaches, Earaches, or Neck pain
☐ Jaw joint pain ☐ Teeth or fillings breaking ☐ Bad breath or taste
☐ Bleeding, swollen, or irritated gums ☐ Loose, chipped or shifting your mouth

What you would like to do to improve your smile:

☐ Whiten ☐ Straighten ☐ Close spaces in teeth
☐ Repair chipped teeth ☐ Replace missing teeth ☐ Replace old mismatching crown

How long has it been since your last dental visit?

☐ Less than one year ☐ 1-2 years ☐ 3-5 years ☐ Over 5 years

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

☐ Dentures ☐ Braces ☐ Partial Dentures ☐ Periodontal (Gum) Treatments ☐ Extractions

(For the following questions please answer with 1 being the least and 10 being the most)

How important is your dental health you you? 1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10
Where would you rate your anxiety about visiting the dentist? 1 2 3 4 5 6 7 8 9 10
What concerns you most about your teeth? _____
Are you interested in regular care or just emergency service? _____

SLEEP HISTORY

Do you currently use a CPAP device or have you ever had a sleep study? ☐ Yes ☐ No
Do you wake up with muscle or joint pain around your jaw? ☐ Yes ☐ No
Does your partner say you snore? ☐ Yes ☐ No

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, _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, _____
Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, _____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes, _____
Do you use tobacco? ☐ Yes ☐ No

WOMEN: Are you: Pregnant/Trying to get pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following?

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

Do you use controlled substances? ☐ Yes ☐ No If yes, _____
Other: _____ If yes, _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

☐ AIDS / HIV Positive	☐ Recent Corticosteroid Use	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis	☐ Anemia
☐ Herpes	☐ Rheumatic Fever	☐ Angina	☐ Emphysema
☐ High Blood Pressure	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Shingles	☐ Artificial Joint
☐ Excessive Thirst	☐ Asthma	☐ Irregular Heartbeat	☐ Blood Disease
☐ Kidney Problems	☐ Leukemia	☐ Stomach / Intestinal Disease	☐ Breathing Problems
☐ Frequent Headaches	☐ Liver Disease	☐ Stroke	☐ Cancer
☐ Lung Disease	☐ Thyroid Disease	☐ Chemotherapy	☐ Chest Pains
☐ Heart Attack / Failure	☐ Osteoporosis	☐ Tuberculosis	☐ Cold Sores / Fever Blisters
☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Congenital Heart Disorder	☐ Heart Pacemaker
☐ Ulcers	☐ Heart Trouble / Disease	☐ Psychiatric Care	

Have you ever had a serious illness not listed ☐ Yes ☐ No If yes _____

COMMENTS:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian Date