GEACH DENTAL

MEDICAL HISTORY AND PATIENT REGISTRATION
(This information is necessary for the doctor and will be considered CONFIDENTIAL)

Last _____ **First** _____ **Middle** _____ **My Preferred Name** _____
Birthdate _____ **Drivers License #** _____ **Social Security #** _____
Residence Address, Unit #, City, State, Zip _____
Mailing Address (if different from above) _____
Home Phone ( ) _____ what is best # to confirm appts? _____
Work Phone ( ) _____ Extension # ____ what is best # to leave personal voice message? _____
Cell Phone ( ) _____
Email _____
Occupation _____ Specialty _____
Employer _____ Address _____ City _____ State ____ Zip _____

Insurance Information Do YOU have **DENTAL Insurance**? YES NO **Subscriber** SELF, SPOUSE, PARENT
Subscriber Name _____ Name of InsCo _____ Phone # of InsCo _____
Subscriber Social Sec # _____ Employer Name and Group # _____
Subscriber Birthday _____ ID # on Ins Card _____

Do you have ANOTHER Dental Insurance? YES NO **Subscriber** SELF, SPOUSE, PARENT
Subscriber Name _____ Subscriber ID # _____ Phone # of InsCo _____
Subscriber Social Sec # _____ Subscriber Birthday _____ Name/Address of InsCo _____
Do you have a PRE TAX FlexSpending, Reimbursement Plan, or HSA Account? NO YES which? _____

Emergency Information (Who to notify in case of Emergency) 1.) Spouse/Domestic Partner _____ Phone ( ) _____
2.) Relative *not* living w/ you _____ Phone ( ) _____ 3.) Business Partner/Friend _____ Phone ( ) _____
Referral Whom may we thank for referring you to our office? _____
If Patient is Minor/Child: Who does child live with full time? _____ Who is financially responsible for child? _____
Is financial responsibility split? How: _____
If College student: School _____ City _____ State _____

Confidential Medical Information Medical Doctor's Name _____ City _____ State _____ Phone ( ) _____

Have you seen a physician in the past 5 yrs for anything other than a routine exam? NO YES explain _____
Have you had heart surgery? Did surgeon suggest you take antibiotics for dental? NO YES Dr name _____ Surg date _____
Have you had a joint replacement? Did surgeon suggest you take antibiotics for dental? NO YES Dr name _____ Surg date _____
Have you ever had intervenous medication for osteoporosis/bone loss (Reclast)? NO YES
Have you ever taken oral meds for osteoporosis? (Aredia, Zometa, Fosamax, Boniva) NO YES
Are you sensitive/allergic to antibiotics in the erythromycin family? (erythromycin, azithromycin, clarithromycin, clindamycin) NO YES
Are you sensitive/allergic to antibiotics in the penicillin family? (PenV, amoxicillin, ampicillin) NO YES
Are you sensitive/allergic to antibiotics in the cephalosporin family? (cephalexin, cephradine, cefazolin, keflex) NO YES
Are you sensitive/allergic to antibiotics in the tetracycline family? NO YES
Are you sensitive/allergic to any pain relievers? (aspirin, ibuprofen, naproxen, celecoxib, acetaminophen, codeine, etc.) NO YES
Other medication allergies such as sulfa or over the counter products? _____ NO YES
Are you sensitive/allergic to dental local anesthetic? NO YES
Are you sensitive/allergic to latex? NO YES
Are you sensitive/allergic to any **metals**? (known allergy) NO YES describe reaction _____
Have you ever been told you were a carrier for Tuberculosis (TB)? NO YES explain _____
Female: Could you be pregnant? NO YES
Do you use tobacco products? (smoke, chew, snuff, etc.) NO YES
Do you use any recreational drugs (marijuana, cocaine, etc) NO YES
Do you take any "prescribed" injectable medications? NO YES explain _____
List "prescribed" oral medications you currently use (if you carry a list, please let us copy it for your chart):

Have you EVER had the following medical problems? Please circle 'Y' for Yes or 'N' for No.

Alcohol / Drug / Chemical Dependency	Y N	Cough Chronic	Y N	Osteoporosis	Y N
Allergies / Hives _____	Y N	Diabetes (type 1 inject / type 2 oral meds)	Y N	Pacemaker	Y N
Epilepsy / Seizures	Y N	Pain in Joints of Jaw / TMJ	Y N	Corneal Transplant	Y N
Abnormal Bleeding / Hemophilia	Y N	Headaches severe	Y N	Psychiatric Problems	Y N
Anxiety Attacks / Nerve Disorders	Y N	Heart Transplant date of surg _____	Y N	Human Papilloma Virus	Y N
Arthritis / Rheumatism / Lupus / Fibromyalgia	Y N	Congenital Heart Disease	Y N	Sinus Problem	Y N
Artificial Joint (hip, knee) date of surg _____	Y N	Heart Infection requiring hospitalization	Y N	Eating Disorder	Y N
Asthma / HayFever / Emphysema / Bronchitis	Y N	HPV warts	Y N	Stroke / Heart attack	Y N
Blood Pressure high ____ low ____	Y N	Hepatitis A / Hepatits B (serum)	Y N	Swollen Neck Glands	Y N
Cancer _____	Y N	HIV Positive / AIDS	Y N	Thyroid Problem hypo / hyper	Y N
Chemotherapy / Radiation	Y N	Kidney Disease	Y N	TB Treat to prevent / to cure	Y N
Canker Sores (inside the mouth)	Y N	Replaced Heart Valve date _____	Y N	VD / Syphilis / Gonorrhea	Y N
Cold Sores / FeverBlistr / Herpes (outside the mouth)	Y N	Liver Disease	Y N	Transfusion	Y N
Difficult Swallow / Gag Reflex / Reflux / Esophag	Y N	Organ Transplant date _____	Y N	Grafts-Tissue / Dura Mater	Y N
Family history of dementia before age 65	Y N	Anaphylactic shock reaction	Y N	Lack of saliva	Y N

ANSWER & CIRCLE ALL CONDITIONS

PATIENT SIGNATURE (parent if minor) _____ **DATE** _____ **Dr. Initial**