Precision
COSMETIC DENTISTRY & DIGITAL DENTURES

8647 WURZBACH RD, BLDG B. SAN ANTONIO, TX 78240
PHONE: 210.691.1211 FAX: 210.693.0525

DENTAL REGISTRATION

PATIENT INFORMATION

DATE _____ SOCIAL SECURITY # _____

NAME (FIRST) _____ (MIDDLE) _____ (LAST) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ SEX ☐ M ☐ F AGE _____ DOB _____

☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ MINOR ☐ SEPARATED ☐ DIVORCED ☐ PARTNERED

PATIENT'S EMPLOYER/SCHOOL _____ EMPLOYER/SCHOOL PHONE _____

EMPLOYER/SCHOOL ADDRESS _____ OCCUPATION _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PHONE NUMBERS

HOME _____ CELL _____ WORK _____ EXT _____

BEST TIME & PLACE TO REACH YOU _____ SPOUSE'S PHONE _____

IN CASE OF EMERGENCY, CONTACT (SPECIFY SOMEONE WHO DOES NOT LIVE IN YOUR HOUSEHOLD)

NAME _____ RELATIONSHIP _____

HOME PHONE _____ WORK PHONE _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental xrays _____

Mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ YES ☐ NO	Chew on one side of mouth	☐ YES ☐ NO
Bleeding gums	☐ YES ☐ NO	Cigarette, pipe or cigar smoking	☐ YES ☐ NO
Blisters on lips or mouth	☐ YES ☐ NO	Clicking or popping jaw	☐ YES ☐ NO
Burning sensation on tongue	☐ YES ☐ NO	Dry mouth	☐ YES ☐ NO
		Fingernail biting	☐ YES ☐ NO
		Food collection between teeth	☐ YES ☐ NO
		Foreign objects	☐ YES ☐ NO
		Jaw pain or tiredness	☐ YES ☐ NO
		Lip or cheek biting	☐ YES ☐ NO
		Loose teeth or broken fillings	☐ YES ☐ NO
		Mouth breathing	☐ YES ☐ NO
		Mouth pain, brushing	☐ YES ☐ NO
		Orthodontic treatment	☐ YES ☐ NO
		Pain around ear	☐ YES ☐ NO
		Periodontal treatment	☐ YES ☐ NO
		Sensitivity to cold	☐ YES ☐ NO
		Sensitivity to heat	☐ YES ☐ NO
		Sensitivity to sweets	☐ YES ☐ NO
		Sensitivity when biting	☐ YES ☐ NO
		Sores or growth in mouth	☐ YES ☐ NO

How often do you floss? _____

How often do you brush? _____

SLEEP QUALITY SCREENING

How likely are you to DOZE OFF or FALL ASLEEP in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, estimate how they would have affected you. Use the following scale to choose the most appropriate number for each situation: 0= no chance 1= slight chance. 2= moderate chance. 3= high chance

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (eg. a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

TOTAL POINTS: _____

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HEALTH HISTORY

PATIENT NAME _____ **DATE** _____

PHYSICIAN'S NAME _____ **DATE OF LAST VISIT** _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex & Fastin (also called phentermine, Pondimin (fenfluramine) and Redux (dexfenfluramine).

Mark "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ YES ☐ NO	Contact Lens Use?	☐ YES ☐ NO	Radiation Treatment	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Epilepsy	☐ YES ☐ NO	Respiratory Disease	☐ YES ☐ NO
Arthritis, Rheumatism	☐ YES ☐ NO	Fainting or Dizziness	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO
Artificial Heart Valves	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	Scarlet Fever	☐ YES ☐ NO
Artificial Joints	☐ YES ☐ NO	Headaches	☐ YES ☐ NO	Shortness of Breath	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO	Sinus Trouble	☐ YES ☐ NO
Back Problems	☐ YES ☐ NO	Heart Problems	☐ YES ☐ NO	Skin Rash	☐ YES ☐ NO
Bleeding abnormally,	☐ YES ☐ NO	Hepatitis Type	☐ YES ☐ NO	Special Diet	☐ YES ☐ NO
with extractions or surgery		Herpes	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
Blood Disease	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Swollen Feet or Ankles	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Jaundice	☐ YES ☐ NO	Swollen Neck Glands	☐ YES ☐ NO
Chemical Dependency	☐ YES ☐ NO	Jaw Pain	☐ YES ☐ NO	Thyroid Problems	☐ YES ☐ NO
Chemotherapy	☐ YES ☐ NO	Kidney Disease	☐ YES ☐ NO	Tonsillitis	☐ YES ☐ NO
Circulatory Problems	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Congenital Heart Lesions	☐ YES ☐ NO	Low Blood Pressure	☐ YES ☐ NO	Tumor or growth on head / neck	☐ YES ☐ NO
Cortisone Treatments	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO	Ulcer	☐ YES ☐ NO
Cough: chronic/bloody	☐ YES ☐ NO	Nervous Problems	☐ YES ☐ NO	Venereal Disease	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Pacemaker	☐ YES ☐ NO	Weight Loss, unexplained	☐ YES ☐ NO
If yes, what is your A1C? _____		Psychiatric Care	☐ YES ☐ NO		
Emphysema	☐ YES ☐ NO				

Women:

Are you pregnant?	☐ YES ☐ NO	Due Date: _____	Are you nursing? ☐ YES ☐ NO
Taking birth control pills?	☐ YES ☐ NO		

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis

_____

_____

_____

_____

_____

Pharmacy _____ Phone _____

Patient's Signature: _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

Doctor's Signature: _____

FOR FUTURE UPDATES ONLY

Have there been any changes to your health since your last dental appointment ☐ YES ☐ NO Date of Update: _____

For what conditions? _____

Are you taking any new medications? ☐ YES ☐ NO If yes, what? _____

Any other changes to your health or well-being? _____

Patient's Signature: _____

Doctor's Signature: _____