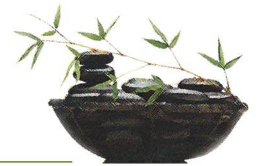
Asai DENTISTRY



Medical History & Patient Registration Form

The information provided on this form is important to your dental health. Please complete all of the questions to the best of your ability. If there have been any changes in your health, please let us know. Questions are welcome and appreciated.

Contact Information

Patient Name (First, middle, last):* ____________________

Email:* ____________________ Cell Phone: ____________________

Home Phone:* ____________________ Preferred way to contact:* ☐ Home Phone

Work Phone: ____________________ ☐ Text ☐ Email ☐ Work Phone

Mailing Address:* ____________________

City:* ____________________ State:* ____________________

Zip:* ____________________

Date of Birth:* ____________________ Race/Ethnicity: ____________________

Gender:* ☐ Male ☐ Female Preferred Language: ____________________

Emergency Contact Name (First, middle, last): ____________________

Emergency Contact Phone: ____________________

Referred By: ____________________

Is Patient a Student?: ☐ Yes ☐ No

Name of School: ____________________ City of School: ____________________

Employment Status: ____________________

Marital Status: ____________________

Other Family Members seen at this office: ____________________

____

Does Patient Have Dental Insurance?*
If yes, please bring insurance card(s) for dental coverage for your visit. ____________________

Guarantor Information

Name (First, middle, Last): ______________________________

Email: ______________________ Cell Phone: ______________________

Home Phone: ______________________ Work Phone: ______________________

Mailing Address: ______________________________

City: ______________________ Date of Birth: ______________________

State: ______________________ Gender: ______________________

Zip Code: ______________________

Health History

Primary Medical Doctor: ______________________________

When was your last physical? ______________________________

Clinic/Doctor/Phone Number: ______________________________

Preferred Pharmacy: ______________________________

Check any medical conditions that you have:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ MS, stroke, seizures
- ☐ High levels of cholesterol
- ☐ Asthma or breathing disorders
- ☐ Allergy - seasonal
- ☐ Artificial heart valve
- ☐ Latex allergy
- ☐ Sinus conditions
- ☐ Weight loss/gain
- ☐ HIV - AIDS
- ☐ Headache
- ☐ Communicable diseases
- ☐ Cancer
- ☐ Cold sores
- ☐ Thyroid trouble
- ☐ Rheumatoid arthritis
- ☐ Shingles/herpes zoster
- ☐ Sleep disorders
- ☐ Ulcers or kidney disorders
- ☐ Heart disease, heart surgery
- ☐ Bacterial endocarditis
- ☐ Cardiac pacemaker
- ☐ Excessive bleeding
- ☐ Artificial joint
- ☐ Hepatitis A, B, C

Are you pregnant? ☐ **Yes** ☐ **No**

Any history of cancer? ☐ **Yes** ☐ **No**

If yes, what kind?: ______________________

____

Any other serious illness that I should know about? ____________________

____

Please list any medications you are currently taking: ____________________

____

Please list any known medications you have had an allergic reaction to: ____________________

____

Dental History

Previous Dentist: ____________________ City: ____________________

Date of last dental visit (if not here): ____________________

What problems have you had with past dental treatments? ____________________

____

Have you had any of the listed? Check all that apply:

- ☐ A tooth or jaw injury
- ☐ Periodontal treatments
- ☐ Orthodontic treatment (braces, etc)
- ☐ Root canal procedure
- ☐ Oral surgery
- ☐ Tooth pain
- ☐ Dry mouth
- ☐ Uneven bite
- ☐ Dental implant
- ☐ Rough/sharp tooth surface
- ☐ Bad breath
- ☐ Radiation treatment of head/neck

Further Questions

Question		
Do your gums bleed when you brush?	☐ Yes	☐ No
I often catch food between my teeth:	☐ Yes	☐ No
Have you had facial or gum swelling?	☐ Yes	☐ No
Do you experience any clicking/popping in your jaw?	☐ Yes	☐ No
Are you aware that you clench or grind your teeth?	☐ Yes	☐ No
Do you have headaches?	☐ Yes	☐ No
Do you have a nightgaurd, splint, snore guard, or orthodontic retainer?	☐ Yes	☐ No
I have or have had jaw pain (TMJ):	☐ Yes	☐ No
Do you use a mechanical (electric) toothbrush?	☐ Yes	☐ No

If yes, which brand? ____________________

Do you use flossing aids (holder, threaders, etc.): ☐ Yes ☐ No

Do you use fluoride treatments or supplements at home? ☐ Yes ☐ No

If yes, which brand? ______________________________

Do you use mouthwashes or oral rinses? ☐ Yes ☐ No

If yes, which brand? ______________________________

Have you ever had any complications from
an extraction or dental treatment?: ☐ Yes ☐ No

If yes, please specify: ______________________________

Social History

Do you live alone? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If so, number of packs/day: __________

Do you consume alcohol? ☐ Yes ☐ No If so, number of drinks/day: __________

Occupation/Recreation

Occupation (if any): ______________________________

Employer (if any): ______________________________

Recreational activities: ______________________________

____

______________________________ ______________
Patient Signature (Parent or Guardian) Date

______________________________ __________ __________ __________
Reviewed By Doctor Date BP Pulse

History Review and Signature Findings: ______________________________

____

Medical Updates

I have read my MEDICAL HISTORY dated ________ and confirm that it adequately states past and present conditions.

Date	Exceptions	Patients Signature	BP	Pulse	Reviewed BY

Thank You! When you are finished with the form, please print it off and bring it to your next appointment!