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:* ☐ Email

Work Phone: _____ ☐ Text ☐ Home Phone ☐ Work Phone

Mailing Address:* _____

City:* _____ State:* _____

Zip:* _____

Date of Birth:* _____ Race/Ethnicity: _____

Gender:* 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
- Any history of cancer? ☐ **Yes** ☐ **No**
- ☐ 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**

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

Further Questions

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 flouride treatments of 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 consume alcohol? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

If so, number of drinks/day: _____

If so, number of packs/day: _____

Occupation/Recreation

Occupation (if any): _____

Employer (if any): _____

Recreational activities: _____

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