Patient’s Registration and History

WELCOME TO DAMEN DENTAL ASSOCIATES!

YOUR INFORMATION

Today’s date:__________________ Email address:____

Legal name:____ Preferred name:_____________________

Last First Middle

Sex (as listed for insurance): □ M / □F Gender identity (optional):_______________ Preferred pronouns:_________________

Birthdate:_______/______/__________ Age:____________________SS#:____

Home Address:____

Street City State Zip

Phone# cell:_________________________, home:__________________________, work:______________________________

Employer:____Occupation:______________________________

Other family members seen by us:____

Whom may we thank for referring you:____

EMERGENCY CONTACT INFORMATION

Name:____

Relation:____Contact #:____________________________________

DENTAL INSURANCE

Primary Dental Insurance

Insurance Company:____ Phone#:______________________________

Group # (or policy#):____Member ID:____________________________

Insurance Address:____

Insured’s name:____Sex: M / F relation:_______________________

Insured’s address:____

Insured’s birthdate:______/_____/____________, Insured’s SS#:____

Insured’s Employer:____

Secondary Dental Insurance

Insurance Company::____ Phone#:_____________________________

Group # (or policy#):____ Member ID:___________________________

Insurance Address:____

Insured’s name:____ relation:_____________________________

Insured’s address: ____

Insured’s birthdate:______/_____/____________, Insured’s SS#:____

Insured’s Employer:____

☞Who is responsible for this account?____ relation:________________________

☞☞☞I affirm that the information is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff at Damen Dental Associates to perform the necessary services I may need. I understand that I am responsible for payment of services rendered and any deductible or copayment that my insurance does not cover.

Signature:____Date:________________________

DENTAL HISTORY

Reason for today's visit:_______________

Previous / Present Dentist:_______________

Date of last dental visit:_______________ Date of last dental X Rays:_______________

Are you currently in pain ....☐Yes ☐No

Do you require antibiotics before dental treatment?...........☐Yes ☐No

Do you have pain in your jaw joint (TMJ/TMD)?.................☐Yes ☐No

Do you have popping/clicking in your jaw joint? ....☐Yes ☐No

Do you snore? .... ☐Yes ☐No

Do you have sleep apnea? ....☐Yes ☐No

Do you wear a CPAP device? ...☐Yes ☐No

Do you wear a bite guard? ....☐Yes ☐No

Have you had any of the following:

Bleeding gums ....☐Yes ☐No

Swollen or tender gums ....☐Yes ☐No

Periodontal treatment ....☐Yes ☐No

Dry mouth ....☐Yes ☐No

Mouth breathing ....☐Yes ☐No

Burning sensation on tongue ....☐Yes ☐No

Cigarette / cigar smoking ....☐Yes ☐No

Vaping ....☐Yes ☐No

Oral Cancer ....☐Yes ☐No

Pain around the ear ....☐Yes ☐No

Orthodontic treatment ....☐Yes ☐No

*do you wear retainers....................☐Yes ☐No

Sensitivity to cold or heat ....☐Yes ☐No

Sensitivity to sweets ....☐Yes ☐No

Sensitivity to biting ....☐Yes ☐No

Loose teeth or broken fillings ....☐Yes ☐No

How often do you floss?_______________ How often do you brush?_______________

Do you use an: ☐ Electric Toothbrush or ☐Manual Toothbrush?

MEDICAL HISTORY

Do you have a primary care physician ☐Yes ☐No Date of last visit:_______________

Physician's name:_______________ phone #:_______________

Your current physical health is: ☐Good ☐Fair ☐Poor

Are you taking any prescription or over-the-counter/ supplemental medications? ☐Yes ☐No

☞Please list medications:_______________

____

Have you ever taken Fosamax or any other bisphosphonate medication for osteoporosis? ☐Yes ☐No

Have you received the COVID vaccine? ☐Yes ☐No

Have you received the HPV (Gardasil) vaccine? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No ☐Unsure, Are you nursing? ☐Yes ☐No

Are you taking birth control medication ☐Yes ☐No, type:_______________

Have you experienced any of the following?

Abnormal bleeding .....☐Yes ☐No

Alcohol/ drug abuse.....☐Yes ☐No

Anemia ....☐Yes ☐No

Artificial joint/valve ......☐Yes ☐No

Asthma ....☐Yes ☐No

Autoimmune Disease ..☐Yes ☐No

Bulimia/ gastric reflux..☐Yes ☐No

Chemotherapy ....☐Yes ☐No

Cancer.....................☐Yes ☐No

Chicken Pox...............☐Yes ☐No

Congenital heart defect ☐Yes ☐No

Diabetes ....☐Yes ☐No

Difficulty breathing ....☐Yes ☐No

Drug abuse ....☐Yes ☐No

Emphysema ....☐Yes ☐No

Epilepsy ....☐Yes ☐No

Fever Blisters/cold sores..☐Yes ☐No

Headaches ....☐Yes ☐No

Heart Attack ....☐Yes ☐No

Heart Murmur ....☐Yes ☐No

Heart Surgery ....☐Yes ☐No

Hepatitis ....☐Yes ☐No

Herpes ....☐Yes ☐No

High Blood Pressure ......☐Yes ☐No

*Low Blood Pressure ....☐Yes ☐No

HIV+/ AIDS ....☐Yes ☐No

Kidney Problems ....☐Yes ☐No

Liver Disease ....☐Yes ☐No

Lupus ....☐Yes ☐No

Mitral Valve Prolapse ....☐Yes ☐No

Osteoporosis................☐Yes ☐No

Pacemaker..................☐Yes ☐No

Psychiatric Treatment.....☐Yes ☐No

Radiation Treatment ......☐Yes ☐No

Seizures ....☐Yes ☐No

Shingles ....☐Yes ☐No

Sinus Problems ....☐Yes ☐No

Steroid Therapy ....☐Yes ☐No

Stroke ....☐Yes ☐No

Thyroid Problems ....☐Yes ☐No

Tonsillitis ....☐Yes ☐No

Venereal Disease ....☐Yes ☐No

Please list any serious medical conditions you have experienced:_______________

Are you Allergic to any of the following?

Aspirin ☐Yes ☐No Dental Anesthetics ☐Yes ☐No Latex ☐Yes ☐No Tetracycline ☐Yes ☐No

Codeine ☐Yes ☐No Erythromycin ☐Yes ☐No Penicillin ☐Yes ☐No Sulfa Drugs ☐Yes ☐No

Other ☐Yes ☐No

Please list anything additional that causes allergic reactions:_______________

Have you ever had a bad/ unusual reaction to dental anesthetics? ☐Yes ☐No

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA