3298 Summit Blvd, Suite 10 • Pensacola, FL 32503
850.434.5247 • Fax 850.433.1530 • www.pensacolafamilydental.net

PATIENT REGISTRATION FORM

Whom may we thank for referring you?
Google__ Social Media__ Existing Patient (Name)_____ Other_____

Patient Name (Mr/Mrs/Ms/Dr)_____ Patient Date of Birth_____
Preferred Name_____Age_____SS#_____Sex: M__F__
Address_____City/St/ZIP_____
Home Phone (_____)_____Work Phone (_____)_____Cell Phone (_____)_____
Email_____Best time of day to reach you_____
Occupation_____Employer_____
Number of Children_____Names and ages of children_____

Please check one: Minor___ Single___ Married___ Widowed___ Separated___ Divorced___

For this section: if minor, please put the parent/guardian's information; if married, please put the spouse's information:
Parent/Guardian OR Spouse Name (Mr/Mrs/Ms/Dr)_____ Date of Birth_____
Preferred Name_____Age_____SS#_____Sex: M__F__
Work Phone (_____)_____Cell Phone (_____)_____Email_____
Occupation_____Employer_____

Emergency Contact Name (Mr/Mrs/Ms/Dr)_____Relationship to patient_____
Home Phone (_____)_____Work Phone (_____)_____Cell Phone (_____)_____
Hospital affiliation (in case of emergency): Hospital Name_____City_____

INSURANCE INFORMATION

Name of Insured_____Is he/she a patient at our practice? Y__N__
Your relationship to insured: Self___ Spouse___ Child___ Other_____
Insurance Plan Name_____Phone Number (_____)_____
Group Number_____Policy/ID Number_____
Driver's License Number_____State_____
Is there additional/secondary insurance coverage? Y__ N__ If yes, please fill out the following:
Name of Insured_____Is he/she a patient at our practice? Y__N__
Your relationship to insured: Self___ Spouse___ Child___ Other_____
Insurance Plan Name_____Phone Number (_____)_____
Group Number_____Policy/ID Number_____

PHARMACY INFORMATION

Name_____Phone Number (_____)_____ City_____

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MEDICAL EVALUATION FORM

Patient Name_____Patient Date of Birth_____
Physician's Name_____Physician's Phone Number (_____)_____
Physician's Location (City/State)_____Date of last visit with physician_____
Are you currently undergoing any medical treatment by a physician? Y__N__ If yes, please explain:
_____
Have there been any changes in your health within the last year? Y__N__ If yes, please explain:
_____
Have you had a serious illness, surgery, or been hospitalized within the last five years? Y__N__ If yes, please explain:
_____
Do you have any allergies (including latex)? Y__N__ Please list: _____
Have you had any problems with prior dental treatment, including any allergic reactions or other complications? Y__N__
If yes, please explain:_____
Main Reason for Today's Dental Visit_____Pain level on scale of 0-10_____

HEALTH HISTORY QUESTIONNAIRE

Indicate if you currently have, or have experienced in the past, any of the following:

1.Y__N__HIV/AIDS
2.Y__N__Herpes
3.Y__N__Hepatitis, Type_____
4.Y__N__Venereal disease (STD)
5.Y__N__Persistent cough or coughing up blood
6.Y__N__Organ transplant
7.Y__N__Recreational drugs or chemical dependency
8.Y__N__Circulation problems
9.Y__N__Postponed treatment due to health concerns
10.Y__N__Liver or gallbladder disease
11.Y__N__High or Low blood sugar
12.Y__N__Seizure, Last Event_____
13.Y__N__Fainting or dizziness, Last Event_____
14.Y__N__Chest pain, Last Event_____
15.Y__N__Suffered from a nervous breakdown
16.Y__N__Do you cry often?
17.Y__N__Feel you need psychiatric care or advice
18.Y__N__Fear/Anxiety with dental visits
19.Y__N__Recent weight loss, fever, or night sweats
20.Y__N__Trauma to face or teeth
21.Y__N__High or Low blood pressure
22.Y__N__Head, neck, back, or jaw injury
23.Y__N__Frequent leg cramps/Restless Leg Syndrome
24.Y__N__Heart disease
25.Y__N__History of infective endocarditis
26.Y__N__Pacemaker, Date_____
27.Y__N__Joint replacement/Implant, Date_____
28.Y__N__Sleep apnea
29.Y__N__Artificial heart valve
30.Y__N__Indwelling defibrillator
31.Y__N__Unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits
32.Y__N__A heart transplant that developed a problem in a heart valve
33.Y__N__A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention
34.Y__N__Any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch/device
35.Y__N__Heart attack, Last Event_____
36.Y__N__Stroke, Last Event_____
37.Y__N__Told to stop medication before treatment
38.Y__N__Congestive heart failure
39.Y__N__Told to take antibiotics before treatment
40.Y__N__Shortness of breath

Patient Name_____Patient Date of Birth_____

41.Y__N__Have been refused life or health insurance?
42.Y__N__Thyroid or adrenal disease
43.Y__N__Asthma, Last Attack Date_____
44.Y__N__Eating disorder
45.Y__N__Tumors or Cancer, Type_____
46.Y__N__Radiation treatment
47.Y__N__Chemotherapy
48.Y__N__Have taken oral bisphosphonates
49.Y__N__Have taken IV bisphosphonates
50.Y__N__Osteoporosis or osteopenia
51.Y__N__COPD, emphysema, or other lung disease
52.Y__N__Sinus problems
53.Y__N__Joint pain or stiffness, including jaw
54.Y__N__Stomach ulcer or acid reflux
55.Y__N__ Is it usually hard to make up your mind?
56.Y__N__Tobacco use (vape,cigarette,cigar)
57.Y__N__Anemia or blood disorder
58.Y__N__Consume alcohol daily
59.Y__N__Prolonged, excessive bleeding after injury
60.Y__N__Behavioral disorder
61.Y__N__Frequent headaches or migraines
62.Y__N__Feel a choking lump in your throat
63.Y__N__Difficulty swallowing
64.Y__N__Swollen neck glands
65.Y__N__Diarrhea, constipation, or bloody stools
66.Y__N__Swollen ankles
67.Y__N__Frequent vomiting or nausea
68.Y__N__Skin disease
69.Y__N__Difficulty urinating or blood in urine
70.Y__N__Kidney or bladder disease
71.Y__N__Constant dry mouth or chapped lips
72.Y__N__Cortisone (steroid) treatment
73.Y__N__Women: trouble during your periods?
74.Y__N__Men: Use of Viagra or Cialis?
75.Y__N__Women: currently pregnant or nursing?
76.Y__N__Men: Prostate trouble?
77.Y__N__Women: if in/past the change of life, do you have trouble with hot flashes or irritability?
78.Y__N__Does life frequently look hopeless?
79.Y__N__Blurred vision or eye disease
80.Y__N__Developmental disorder
81.Y__N__Often feel shaky/weak if don't eat on time
82.Y__N__Blood Transfusion
83.Y__N__Frequent numbness/tingling in your body
84.Y__N__Gout
85.Y__N__Poor memory or lack of concentration
86.Y__N__Are you under abnormal stress?
87.Y__N__Do you get your feelings hurt easily?
88.Y__N__Frequent nosebleeds

The following questions are regarding your immediate family's history (mother, father, siblings):

89.Y__N__Convulsions/Seizures/Nervousness
90.Y__N__Nervous exhaustion/breakdown
91.Y__N__Heart issues/High blood pressure/Stroke
92.Y__N__Asthma/Hay fever/Food allergies
93.Y__N__Rheumatoid arthritis/Alcoholism/Cancer
94.Y__N__Diabetes/Obesity/Stomach trouble
95.Y__N__Frequent headaches/sickness
96.Y__N__Prolonged, excessive bleeding

IS THERE ANYTHING IN YOUR MEDICAL HISTORY THAT WE HAVE NOT ALREADY ASKED ABOUT? Y__N__If yes, please explain: _____
_____

MEDICATION LIST

(please list any medications you are currently taking, including any medications/supplements that have not been prescribed and you are taking on your own)

	Medication Name	Dosage (in mg or ml)	Times Per Day	Reason	Date started taking
1.					
2.					
3.					
4.					
5.					
6.					

Patient Name_____Patient Date of Birth_____

7. _____ _____ _____ _____ _____
8. _____ _____ _____ _____ _____
9. _____ _____ _____ _____ _____
10. _____ _____ _____ _____ _____
11. _____ _____ _____ _____ _____
12. _____ _____ _____ _____ _____
13. _____ _____ _____ _____ _____
14. _____ _____ _____ _____ _____
15. _____ _____ _____ _____ _____

I have reviewed and verified the accuracy of the information on this medical evaluation form. I understand this information will be used by the Pensacola Family Dental Associates staff to help determine appropriate and healthful dental treatment. I will inform my dentist of any change in my health and/or medication. Since at each visit the work to be done is explained to me and any questions I may have are answered prior to treatment, I give Pensacola Family Dental Associates my consent to perform any needed dental treatment.

Patient/Guardian Signature: _____Date: _____
Patient/Guardian Signature: _____Date Updated: _____
Patient/Guardian Signature: _____Date Updated: _____
Patient/Guardian Signature: _____Date Updated: _____

MEDICAL EVALUATION NOTES (for office use):

_____

_____

_____

_____

_____

_____

_____

_____

Dentist Signature: _____Date: _____
Dentist Signature: _____Date: _____
Dentist Signature: _____Date: _____
Dentist Signature: _____Date: _____

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DENTAL EVALUATION FORM

Patient Name_____Patient Date of Birth_____
Name of Previous Dentist_____Date of last dental exam_____
Date of last set of dental x-rays_____Date of last cleaning_____
Dental treatment that was recommended by previous dentist that has not been completed, if any:
_____
Main Reason for Today's Dental Visit_____Pain level on scale of 0-10____

Indicate if you currently have, or have experienced in the past, any of the following:

1.Y__N__Constant bad breath or sour taste in mouth
2.Y__N__Pains of the face or jaw or ears
3.Y__N__Burning sensation or scalded feeling in mouth
4.Y__N__Clicking or locking of jaw
5.Y__N__Constant dry mouth or chapped lips
6.Y__N__Sensitivity to hot or cold or sweets
7.Y__N__Grinding or clenching of teeth
8.Y__N__Difficulty opening mouth wide
9.Y__N__Frequent headaches or migraines
10.Y__N__Sensitive gag reflex
11.Y__N__Complications after dental treatment
12.Y__N__Snoring
13.Y__N__Difficulty with chewing or biting
14.Y__N__Gums shrink away from teeth
15.Y__N__Frequently bleeding gums
16.Y__N__Food caught between teeth
17.Y__N__Broken or chipped or cracked teeth
18.Y__N__Fear/Anxiety with dental visits
19.Y__N__Bad experience with previous dentist
20.Y__N__Trauma to face/teeth
21.Y__N__Frequent fever blisters or sores in mouth
22.Y__N__Head, back, neck, or jaw injury
23.Y__N__Consume citrus or fruit juices daily
24.Y__N__Loose or wiggly teeth
25.Y__N__Scaling/root planing ("deep cleaning")
26.Y__N__Wear a night guard
27.Y__N__Wear a removable retainer
28.Y__N__Wear a mouth guard
29.Y__N__Frequently tender gums
30.Y__N__Wear dentures or partials
31.Y__N__Root canal
32.Y__N__Prolonged or excessive bleeding
33.Y__N__Bleeding from the mouth for no reason
34.Y__N__Prescription toothpaste
35.Y__N__Swelling in or around mouth
36.Y__N__Fluoride treatment
37.Y__N__Told to stop medication before treatment
38.Y__N__Extraction of wisdom teeth
39.Y__N__Told to take antibiotics before treatment
40.Y__N__Extraction of non-wisdom teeth
41.Y__N__Postponed treatment for health concerns
42.Y__N__Dry socket
43.Y__N__Wearing of braces to straighten teeth
44.Y__N__Coating on tongue
45.Y__N__Allergic reaction during dental visit
46.Y__N__Teeth whitening/bleaching
47.Y__N__Biting of lip/cheek/fingernails/objects
48.Y__N__Chew gum daily
49.Y__N__Cracks at corners of mouth
50.Y__N__Use tobacco products
51.Y__N__Use a "hard" or "medium" toothbrush
52.Y__N__Calculus/tartar
53.Y__N__Floss less than once per day
54.Y__N__Brush less than twice daily
55.Y__N__Avoid dairy products
56.Y__N__Eat sweets between meals
57.Y__N__Laughing gas for sedation dentistry
58.Y__N__Consume alcohol daily
59.Y__N__Taken a pill for sedation dentistry
60.Y__N__Dental implants

Patient/Guardian Signature: _____ Date: _____