Dr. Thomas Llewellyn, D.D.S.
Dr. David Denisch, D.D.S.
Registration Form

Date _____

Patient's Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone # _____Work Phone # _____

Cell Phone # _____Email Address: _____

Sex _____ Male _____ Female Date of Birth _____

Social Security # _____

Marital Status ____ Single ____Married _____Divorced _____Separated _____Widowed

If patient is a minor, parent or guardian name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____

Street Address _____

Home Phone # _____Work Phone # _____

Social Security # _____Date of Birth _____

Relationship to Patient _____ Occupation _____

Employer _____Business Address _____

Dental Insurance Information

Dental Insurance Name _____

Do you have dual coverage? _____Yes _____ No

If Yes: Secondary Dental Insurance Name _____

Date of Birth of Policy Holder _____Insured SSN _____

Emergency Information

Person to contact in case of an emergency _____

Dental History

Previous Dentist _____

When was your last dental visit/examination? _____

Last cleaning? _____ Last X-ray's _____

Do you have any concerns about your dental health? _____ Yes _____ No

If yes, describe_____

Are you satisfied with the appearance of your teeth? _____ Yes _____No

What would you change if you could? _____

How often do you brush? _____ Floss? _____

Do you use an electric toothbrush? ____ Yes ____ No What brand?_____

Do you use any other oral hygiene products? _____

Check ALL of the following which apply: (past or present)

____Injury to the Face or Jaw ____Sensitivity to hot ____Sensitivity to cold

____Aches in Jaw joint ____Frequent Fever Blisters ____Mouth Ulcers

____Bleeding Gums ____Mouth Odor ____Bad taste in mouth

____Clenching/Grinding ____Clicking/Popping Jaw ____Loose or Painful Teeth

____Orthodontic Treatment ____Periodontal Treatment ____Change in Bite

Do you presently smoke or use smokeless tobacco? ____ Yes ____ No

If yes, how long and how much? _____

Do you have any dental problems which require immediate attention? _____

Do you have any other dental concerns?_____

I hereby authorize Dr. Llewellyn/Dr. Denisch and/or their staff to furnish and release information concerning my treatments and examinations as requested by insurance carriers, physicians, laboratories, or other dentists to whom I am referred by Dr. Llewellyn's/
Dr. Denisch's office. I also understand that I am financially responsible for all dental treatment fees.
Signed _____ Date _____

HEALTH HISTORY INFORMATION

PATIENT'S NAME _____ DATE _____

Date of Last Physical Examination _____

Physician's Name _____ Phone_____

Physician's Address_____

City / State / Zip Code _____

	Yes	No	Unsure
Are you in good health?	□	□	□
Have there been any changes in your general health within the past year?	□	□	□
Are you under the care of a physician?	□	□	□

If yes, what is/are the conditions being treated?

_____

_____

_____

	Yes	No	Unsure
Are you taking, or have you recently taken any medicine(s)	□	□	□

If so, what medicine(s) are you taking?

Prescribed _____

_____

_____

Over the counter _____

_____

Vitamins, natural or herbal preparations and/or diet supplements _____

_____

Are you allergic to or have had a reaction to:

	Yes	No	Unsure
Animal	□	□	□
Aspirin	□	□	□
Barbiturates, Sedatives, Sleeping Pills	□	□	□
Codeine or Other Narcotics	□	□	□
Food (specify) _____			
Hay Fever / Seasonal	□	□	□
Iodine	□	□	□
Latex	□	□	□
Local Anesthetics	□	□	□
Metals (specify) _____			
Penicillin or Other Antibiotics	□	□	□
Sulfa Drugs	□	□	□

Other _____

	Yes	No	Unsure
Have you ever had serious illness, operation or been hospitalized in the past five years?	□	□	□

If yes, what illness or problem? _____

_____

_____

_____

_____

_____

	Yes	No	Unsure
Do you drink alcoholic beverages?	□	□	□

If yes, how much do you consume, on average in a week's time? _____

	Yes	No	Unsure
Do you use drugs or other substances for recreational purposes?	□	□	□

If yes, please list _____

_____

	Yes	No	Unsure
Do you use tobacco (smoking, snuff, chew)?	□	□	□

If so, how much? _____

	Yes	No	Unsure
Have you had an orthopedic **total** joint replacement?	□	□	□

If yes, when? _____

	Yes	No	Unsure
Has a physician or previous dentists recommended that you take antibiotics prior to you dental treatment?	□	□	□

If yes, what antibiotic and dose? _____

_____

	Yes	No	Unsure
Abnormal Bleeding	□	□	□
AIDs or HIV Infection	□	□	□
Anemia	□	□	□
Arthritis	□	□	□
Rheumatoid Arthritis	□	□	□
Asthma	□	□	□
Blood Transfusion	□	□	□
If yes, date _____			
Cancer/Chemotherapy/ Radiation	□	□	□

Cardiovascular Disease (If yes, specify)

__Angina
__Arteriosclerosis
__Artificial Heart Valves
__Congenital Heart Defects
__Congestive Heart Disease
__Coronary Heart Disease
__Damaged Heart Disease
__Defibrillator
__Heart Attack
__Heart Murmur
__High Blood Pressure
__Low Blood Pressure
__Mitral Valve Prolapse
__Pacemaker
__Rheumatic Heart
__Rheumatic Fever
__Stroke

Chest Pain upon Exertion	□	□	□
Chronic Pain	□	□	□
Depression/Anxiety	□	□	□
Disease/Drug/Radiation induced Immunosuppression	□	□	□
Diabetes	□	□	□
If yes, specify below: __Type I (Insulin Dependent __Type II			
Dry Mouth	□	□	□
Eating Disorder	□	□	□
If yes, please specify _____			
Epilepsy	□	□	□
Fainting Spells or Seizures	□	□	□
Gastrointestinal Disease	□	□	□
G.E. Reflux / Persistent Heartburn	□	□	□
Glaucoma	□	□	□
Hemophilia	□	□	□
Hepatitis, Jaundice or Liver Disease	□	□	□
Recurrent Infections	□	□	□
If yes, type of infection _____			

	Yes	No	Unsure
Kidney Problems	□	□	□
Mental Health Disorders	□	□	□
Malnutrition	□	□	□
Night Sweats	□	□	□
Neurological Disorders	□	□	□
Osteoporosis	□	□	□
Persistent Swollen Glands in Neck	□	□	□
Respiratory Problems	□	□	□
____ Emphysema ____ Bronchitis (etc.)			
Severe Headaches / Migraines	□	□	□
Severe or Rapid Weight Loss	□	□	□
Sexually Transmitted Disease	□	□	□
Sinus Trouble	□	□	□
Sleep Disorder	□	□	□
Sores or Ulcers in the Mouth	□	□	□
Systemic Lupus Erythematosus	□	□	□
Tuberculosis	□	□	□
Thyroid Problems	□	□	□
Ulcers	□	□	□
Excessive Urination	□	□	□

Do you have any disease, condition or problem listed above you think I should know about?
Please explain: _____

_____

_____

_____

_____

Women Only

	Yes	No	Unsure
Are you or could you be pregnant?	□	□	□
Nursing?	□	□	□
Taking birth control pills or hormone replacement?	□	□	□

_____

NOTE: Both doctor and patients are encouraged to discuss any and all relevant patient health care issues prior to treatment. I certify that I have read and understand the above. I will **not** hold my dentist, or any other member of his staff, responsible for any action they take, or do not take, because of errors or omissions that I may have made in the completion of this form.

_____

SIGNATURE OF PATIENT / LEGAL GUARDIAN **DATE**