Pompton Family Dental Services

Date _____

PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: ___ Sex: M ☐ F ☐

Birth Date: _____ Social Security Number: _____ Height: _____ Weight: _____

Email: _____ Home Phone: _____ Cell Phone: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____

Business number: _____ Martial Status: Married ☐ Single ☐ Spouse: _____

Person Responsible for Account: _____

Physician: _____ Office Phone: _____

Pharmacy Name: _____ Town: _____ Pharmacy Phone: _____

How did your hear about us? _____

PATIENT MEDICAL HISTORY

		Yes	No
1.	Are you under any medical treatment now?	☐	☐
2.	Have you had any major operations? if so, what?	☐	☐
3.	Have you ever had a serious accident involving head injuries?	☐	☐
4.	Have you ever had any adverse response to any drugs including penicillin?	☐	☐
5.	Has a physician ever informed you that you had : A Heart Ailment?	☐	☐
6.	High Blood Pressure?	☐	☐
7.	Respiratory Disease?	☐	☐
8.	Diabetes?	☐	☐
9.	Rheumatic Fever?	☐	☐
10.	Rheumatism or Arthritis?	☐	☐
11.	Tumors or Growths?	☐	☐
12.	Any Blood Disease?	☐	☐
13.	Any Liver Disease?	☐	☐
14.	Any Kidney Disease?	☐	☐
15.	Any Stomach or Intestinal Disease?	☐	☐
16.	Any Venereal Disease?	☐	☐
17.	Yellow Jaundice or Hepatitis?	☐	☐
18.	Are you now taking drugs or medication?	☐	☐
19.	Are you allergic to any known materials resulting - in hives, asthma, eczema, etc.?	☐	☐
20.	Have any wounds healed slowly or presented other complications?	☐	☐
21.	Are you pregnant?	☐	☐
22.	Do you have history of fainting?	☐	☐
23.	Have you ever had any X-RAY TREATMENTS (other than diagnostic)?	☐	☐
24.	Do you have pain in or near your ears?	☐	☐
25.	Do you have any unhealed injuries or inflamed areas in or around your mouth?	☐	☐
26.	Have you experienced any growth or sore spots in your mouth?	☐	☐
27.	Does any part of your mouth hurt when clenched?	☐	☐
28.	Have you ever had Novocaine anesthetic?	☐	☐
29.	Any reactions or allergic symptoms to Novocaine?	☐	☐
30.	Any difficult extractions in the past?	☐	☐
31.	Prolonged bleeding following extractions in the past?	☐	☐
32.	Do your gums bleed?	☐	☐
33.	When was your last full mouth X-RAY taken? _____ Where? _____		
34.	Any part of your mouth sore to pressure or irritants (cold, sweets, etc.)	☐	☐
35.	If so locate _____		
36.	Do you have any symptoms related to AIDS?	☐	☐

Signature: _____