

PATIENT REGISTRATION

ID: _____ Chart ID: _____
First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City, State, Zip: _____ Pager: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
Birth Date: _____ Soc Sec: _____ Drivers Lic: _____
 Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____
City: Fresno State / Zip: _____ Pager: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____
E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired
Student Status: Full Time Part Time
Medicaid ID: _____ Pref. Dentist: J. Art Mirelez Jr., DDS, FICOI, FAC
Employer ID: _____ Pref. Pharmacy: _____
Carrier ID: _____ Pref. Hyg.: _____

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____
Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____
Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

- Dental History -

TO ASSIST US WITH YOUR THOROUGH EXAM, PLEASE FILL OUT TO THE BEST OF YOUR ABILITY, THANK YOU ©

Referred by: _____ What condition is your mouth in: Excellent Good Fair Poor
 Previous Dentist: _____ Whom I had been a patient for _____ Months / Years (circle)
 Last dental exam: _____ (months/years) ago. Last x-rays: _____ (months/years) ago. Last treatment: _____ (months/years) ago.
 I routinely see my dentist every: 3 mos. 4 mos. 6 mos. 12 mos. I do not go routinely
WHAT IS YOUR IMMEDIATE OR MAIN CONCERN TODAY? _____

PLEASE CHECK "YES" OR "NO" TO THE FOLLOWING. HELPFUL COMMENTS ARE ENCOURAGED FOR THE "YES" ANSWERS: YES NO

PERSONAL HISTORY Risk: Low Mod High

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10(very) _____

Have you ever had an unfavorable dental experience? _____

Have you ever had complications from past dental treatment? _____

Have you ever had trouble getting numb or reactions to local anesthetic? _____

Have you had any teeth removed? _____

Did you ever have braces, orthodontic treatment or had your bite adjusted? If yes, by who _____

GUM AND BONE Risk: Low Mod High

Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____

Have you ever experienced gum recession (gums shrinking around teeth)? _____

Have you ever had any teeth become loose on their own (without an injury)? _____

Is there anyone in your family with a history of periodontal gum disease? _____

Do your gums currently bleed when brushing, flossing or eating? _____

Do you have difficulty eating an apple due to loose teeth? _____

Have you ever noticed an unpleasant taste or odor in your mouth? _____

Have you ever smoked tobacco or currently smoke tobacco? (circle) _____

Have you experienced a burning sensation in your mouth? _____

TOOTH STRUCTURE Risk: Low Mod High

Have you had any cavities within the past 3 years? _____

Do your parents or siblings have "bad teeth"? _____

Does the amount of saliva in your mouth seem too little (dry mouth) or do you have difficulty swallowing any food? _____

Are any teeth currently sensitive to hot, cold, biting or sweets or do you avoid brushing any sensitive teeth? _____

Do you frequently snack on high sugar food/drinks throughout the day (soda, candy, cookies)? _____

Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____

Do you get food caught between teeth? _____

Do you have grooves or notches on your teeth near the gum line? _____

Have you ever had a habit of sucking on lemons or eating a lot of citrus? _____

Do you drink high acidic beverages on a daily basis (coffee, tea, lemonade, orange juice, soda, wine, power drinks)? _____

Have you ever experienced gastric acid reflux (acid coming up from stomach into your mouth, sour taste)? _____

BITE AND JAW JOINT Risk: Low Mod High

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)? _____

Do you or would you have any trouble chewing gum? _____

Do you or would you have any problems chewing bagels, baguettes, protein bars or other hard foods? _____

Have your teeth changed in the last 5 years, become shorter, chip, thinner or worn? _____

Are your teeth crowding or developing spaces? _____

Do you have more than one bite and squeeze to make your teeth fit together? _____

When bringing your teeth together, do you find that you have to search for a comfortable bite? _____

Do you clench your teeth in the daytime or make them sore? _____

Do you chew ice, bite your nails, use your teeth to hold objects or have any other abnormal oral habits? _____

Do you have problems with sleep or wake up with an awareness of your teeth? _____

Do you have pain or soreness in the muscles of your face? Where? _____

Do you grind your teeth at night? _____

Do you or have you ever worn a bite appliance (Niteguard, Splint)? _____

SMILE CHARACTERISTICS Risk: Low Mod High

Are you unhappy with the appearance of your teeth? _____

Have you been disappointed with the appearance of previous dental work? _____

Have you ever bleached (whitened) your teeth? _____

Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____

Is there anything about the appearance of your teeth that you would like to change? _____

Would you like to address any of your cosmetic concerns at this time? (Is the timing good?) _____

Patients Name: _____ Patients Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

MEDICAL HISTORY

Patient Name: _____ Nickname: _____ Age: _____

Name of Physician/and their specialty: _____ Phone #: _____

Most recent physical examination: _____ Purpose: _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD

		YES	NO			YES	NO
1. Hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Osteoporosis/Osteopenia _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. An allergic reaction to: (Circle) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you been treated w/ Bisphosphonate drug's? (circle) _____ (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva, RANKL, Denosumab, Prolia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin Ibuprofen Acetaminophen				P 29. Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine Penicillin Erythromycin				30. Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tetracycline Sulpha Local anesthetic				31. Contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flouride Metals (nickel, gold, silver) Clindamycin				32. Head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Valuim or other sedatives Latex				33. Epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any of these Medications? (Circle) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34. Neurologic problems (attention deficit disorder) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tagamet® (cimetidine) Prilosec® (omeprazole)				35. Viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardizem® (diltiazem) Calan, Isoptin® (Verapamil)				36. Any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre-medication before dental treatment				37. Hives, skin rash, hay fever(circle) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serzone® (nefazodone) Dilantin® Tegretol				38. Venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates (any) Biaxin® (clarithromycin)				39. Hepatitis (type ____) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
St. John's Wort, Kava-Kava				40. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P 4. Heart problems or cardiac stent within the last six months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41. Tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. History of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B 42. Radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Artificial heart valve, repaired heart defect _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B 43. Chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P 7. Pacemaker, implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P 44. Emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Artificial replacement joints (Year?) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45. Psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B 46. Antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P 10. High or Low blood pressure (circle) Your normal BP= _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BP 47. Alcohol, Drug dependency (circle) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. A stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48. Please provide current weight: _____			
12. Anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:			
13. Prolonged bleeding due to slight cut (INR>3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49. Presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Emphysema, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	50. Aware of a change in your general health _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51. Taking medication for weight management (fen-phen) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	52. Taking dietary supplement _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Breathing, Sleeping problems, Snoring, Sinus (circle) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	53. Often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	54. Subject to frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P 55. A smoker or smoked previously (circle) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	56. Considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Thyroid, Parathyroid disease (circle) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	57. Often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	58. Consume grapefruit juice, grapefruits or grapefruit extract? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. High cholesterol, taking statin drugs (circle) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	59. MALE - prostate disorders: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P 24. Diabetes (HbA1c) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	60. FEMALE - Taking Birth Control pills _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B 25. Stomach, duodenal ulcer (circle) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	61. FEMALE - Pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B 26. Digestive disorders, Gastric/acid reflux _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and or vitamins taken in the last two years

Drug	Dosage	Purpose	Drug	Dosage	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____