

# FOLSOM STREET DENTAL

## Patient Registration Form

Date: \_\_\_\_\_

### About You

1. Patient's Name: \_\_\_\_\_  
Last First MI
2. Gender (circle) Male Female Transgender
3. Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_
4. Street Address: \_\_\_\_\_
5. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
6. Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Cell Phone: ( ) \_\_\_\_\_ Other Phone: ( ) \_\_\_\_\_  
E-mail Address: \_\_\_\_\_
7. Referred by: \_\_\_\_\_
8. Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_
9. Marital Status (circle) Single Married Divorced Separated Widowed
10. Disability(circle) Yes No

### Emergency Contact Information

1. Name of emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_
2. Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Cell Phone: ( ) \_\_\_\_\_ Other Phone: ( ) \_\_\_\_\_
3. Medical doctor name: \_\_\_\_\_ Office Phone: ( ) \_\_\_\_\_

### Financial Responsible Party (If it is same as the patient, proceed to Insurance Information).

1. Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
2. SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

3. Street Address: \_\_\_\_\_  
4. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
5. Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Cell Phone: ( ) \_\_\_\_\_ Other Phone: ( ) \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

**Dental Insurance Information (Primary)**

1. Insurance Co. Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
2. Policy number: \_\_\_\_\_ Group number: \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
3. Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First MI  
Relation to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_

**Dental Insurance Information (Secondary)**

1. Insurance Co. Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
2. Policy number: \_\_\_\_\_ Group number: \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
3. Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First MI  
Relation to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_

# Folsom Street Dental

## PATIENT MEDICAL HISTORY FORM

**PATIENT'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ **Chart #:** \_\_\_\_\_

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATIONS THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO		YES	NO
1) Are you in Good Health? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	11) Have you ever required a Blood Transfusion? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Height _____ Weight _____			12) Have you had a recent weight loss? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
2) Have there been any changes in your health within the past year? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	13) Have you ever taken Fen-Phen / Redux? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
3) Date of your last Physical Exam: _____			14) Do you use tobacco? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
4) Physician's Name _____			15) Do you or have you used Controlled Substances? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Address _____			16) Are you wearing contact lenses? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Phone Number (_____) _____			17) Do you have a persistent cough or throat clearing not associated with a known Illness (lasting more than 3 weeks)? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you now under the care of a physician? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	18) Do you have any disease, condition or problems not listed above that I should know about? _____	<input type="checkbox"/>	<input type="checkbox"/>
6) Have you been hospitalized for any Surgical Operations or Serious Illness? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>			
Please explain _____					
7) Are you taking any Medicine (s)? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>			
Including non-prescription Medicine. If Yes, list the medicine (s) you are taking: _____					
8) Are you taking <i>Bisphosphonate</i> Medication (s)? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>			
9) Have you had any Abnormal Bleeding? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>			
10) Do you bruise easily? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>			

**WOMEN ONLY:**

Are you pregnant or think you may be Pregnant? Week # \_\_\_\_\_

Are you nursing? . . . . .

Are you taking birth control pills? . . . . .

	YES	NO		YES	NO
<b>ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:</b>			Glaucoma . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Local Anesthetics like Novocaine . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other Antibiotics . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Heart Congenital Problems . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Codeine . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Heart Defect or Heart Murmur . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, Sedatives or Sleeping Pills . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble, Heart Attack, or Angina . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, Jaundice, or Liver Disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Iodine . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Herpes . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Any Metals (E.G., Nickel, Mercury, ETC.) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Skin rash . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Latex / Rubber . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list) _____			Joint Replacement or Implant . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
<b>DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:</b>			Kidney Trouble. . . . .	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Allergies . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Lung or Breathing Problems . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Anemia . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis or Rheumatism . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Asthma . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure High . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure Low . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Heart Disease or Rheumatic Fever. . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy (Cancer / Leukemia) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores or Fever Blisters . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Treatment . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Snoring / Sleep Apnea . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces Blood . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Cough Persistently . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Stroke . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Feet, Ankles, Hands . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorders . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or Seizures . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or Dizzy spells. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
			Tumors . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
			Osteoporosis/ Osteopenia/ Oste	<input type="checkbox"/>	<input type="checkbox"/>

## PATIENT DENTAL HISTORY FORM

**PATIENT'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ **Chart #:** \_\_\_\_\_

Reason for this visit \_\_\_\_\_  
 Are you currently in pain \_\_\_\_\_  
 When was your last dental visit \_\_\_\_\_ what was done then \_\_\_\_\_  
 How often did you visit the dentist before then \_\_\_\_\_  
 Previous dentist (Name and Location) \_\_\_\_\_  
 Have you had a complete series of dental films (x-rays) taken, when, where \_\_\_\_\_  
 How often do you brush your teeth \_\_\_\_\_ How often do you floss your teeth \_\_\_\_\_  
 Is your drinking water fluoridated \_\_\_\_\_  
 Do you require antibiotics before dental treatment? \_\_\_\_\_

	YES	NO		YES	NO
Do your gums bleed while brushing Or flossing? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot or cold Liquids/Foods? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed any loosening of Teeth? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to sweet or sour Liquids/Foods? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Does food tend to become caught between your teeth? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain to any of your teeth? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had PERIODONTAL treatment (gums)? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any sores or lumps in or Near your mouth? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Ever worn a bite plate or other appliance?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any head, neck, or jaw Injuries? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any difficult extractions in the past? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experience any of the Following problems in your jaw?			Have you ever had any prolonged bleeding following extractions? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Clicking . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Pain (Joint, Ear, Side of Face)? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	If yes, Date of placement _____		
Difficulty in opening or closing? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever received Oral Hygiene Instructions regarding the care of		
Difficulty in chewing? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	your teeth and gums? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent headaches? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a prosthetic Joint / Implant?... .	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your teeth? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	If so, describe where _____		
Do you have any mobility in your teeth? . . .	<input type="checkbox"/>	<input type="checkbox"/>			

If you could change anything about your smile, what would you change?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**AUTHORIZATION AND RELEASE:**  
 I CERTIFIED THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION COULD BE DANGEROUS TO MY HEALTH. I AUTHORIZED CHEEMA DENTAL CORPORATION TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZED AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENTS OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

**X** \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of patient/or guardian if minor

Doctor's comments  
 \_\_\_\_\_  
 \_\_\_\_\_

**X** \_\_\_\_\_ Date \_\_\_\_\_  
 Doctor's Signature