

BURKE DENTAL, PLLC ADULT REGISTRATION FORM

LAST NAME		FIRST NAME		MI	SSN
DOB	GENDER: M / F	MARITAL STATUS: S / M / D / W		NAME OF SPOUSE	
ADDRESS					
CITY		STATE	ZIP	REFERRED TO OFFICE BY	
HOME PHONE			WORK PHONE	CELL PHONE	
YOUR E-MAIL ADDRESS			EMPLOYER		
SPOUSE'S EMPLOYER			SPOUSE'S WORK PHONE	SPOUSE'S CELL PHONE	
PHYSICIAN			PHONE	CITY/STATE	
EMERGENCY CONTACT			EMERGENCY PHONE	PHARMACY PHONE	

MEDICAL HISTORY

Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION
		ABNORMAL BLEEDING			GLAUCOMA			STROKE
		ALCOHOL ABUSE			HIV+ AIDS			THYROID PROBLEMS
		ALLERGIES			HAY FEVER			TUBERCULOSIS
		ANEMIA			HEART ATTACK			ULCERS
		ANGINA PECTORIS			HEART MURMUR			YELLOW JAUNDICE
		ARTHRITIS			HEART SURGERY			ALLERGIES
		ARTIFICIAL BONES			HEMOPHILIA			ASPIRIN
		ARTIFICIAL HEART VALVE			HEPATITIS A			CODEINE
		ASTHMA			HEPATITIS B			DENTAL ANESTHETICS
		BLOOD TRANSFUSION			HEPATITIS C			ERYTHROMYCIN
		CANCER-CHEMOTHERAPY			HIGH BLOOD PRESSURE			JEWELRY
		COLITIS			HPV			LATEX
		CONGENITAL HEART DEFECT			KIDNEY PROBLEMS			METALS
		COSMETIC SURGERY			LIVER DISEASE			PENICILLIN
		DIABETES			LOW BLOOD PRESSURE			TETRACYCLINE
		DIFFICULTY BREATHING			MITRAL VALVE PROLAPSE			OTHER ALLERGIES
		DRUG ABUSE			PREMED			
		EMPHYSEMA			PACE MAKER	Y	N	
		EPILEPSY			PAIN IN JAW JOINTS			SMOKE OR CHEW TABACCO?
		FAINTING SPELLS			PSYCHIATRIC PROBLEMS			FEMALES ONLY:
		FEVER BLISTERS			RHEUMATIC FEVER			PREGNANT OR NURSING
		FREQUENT HEADACHES			SEIZURES			TAKING BIRTH CONTROL PILLS
					SINUS PROBLEMS			

PLEASE LIST ALL MEDICATIONS THAT YOU ARE PRESENTLY TAKING:

HAS ANYONE EVER TOLD YOU THAT YOU SNORE? Y / N

IS THERE ANY DISEASE, CONDITION, OR PROBLEM THAT YOU THINK THIS OFFICE SHOULD KNOW ABOUT THAT IS NOT COVERED ABOVE?

HAVE YOU EVER TAKEN ANY BISPSPHONATES MEDICATIONS (such as Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, Zometa, or Reclast)? Y / N

HAVE YOU EVER HAD ANY BAD EXPERIENCES AT THE DENTAL OFFICE?

IS THERE ANYTHING THAT YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE?

OFFICE POLICIES AND CONSENT FOR TREATMENT

BEFORE TREATMENT CAN BE RENDERED, ADEQUATE RADIOGRAPHS OF THE TEETH AND MOUTH MUST BE TAKEN.

WE USE LOCAL ANESTHETIC AND OTHER METHODS OF PAIN CONTROL TO MAKE OUR PATIENTS MORE COMFORTABLE WHILE RECEIVING DENTAL TREATMENT.

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, CONSENT TO THE PERFORMING OF DENTAL OR ORAL SURGICAL PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE, AND I WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THOSE PROCEDURES.

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, WAS GIVEN A COPY OF BURKE DENTAL, PLLC NOTICE OF PRIVACY PRACTICES.

INSURANCE INFORMATION

Sponsor's Name	Sponsor's DOB	Sponsor's SSN
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PRINT YOUR NAME

SIGNATURE	DATE
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For Office Use Only: Entered by _____ Checked by _____ Scanned By _____