209 BROOKLINE DENTAL

EXCEEDING EXPECTATIONS

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REGISTRATION FORM

Today's date:						
PATIENT INFORMATION						
Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
If child, Parent's Name			Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security number:		Day time phone number: ( )		
City:	State:	ZIP Code:	Email:			
Occupation:	Employer:		Employer phone no.: ( )			
Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Internet	❑ Other		
Other family members seen here:						

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Policyholder name:	Policyholder birth date: / /	Policyholder Social Security number:	Home phone no.: ( )
Address (if different):			
Is this person a patient here?	❑ Yes ❑ No		
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance?	❑ Yes ❑ No		
Insurance company:			
Group number:	Policy number:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PERSONAL HEALTH HISTORY			
Primary care physician:	Phone:	May we request health information if necessary for our treatment?	❑ Yes ❑ No
Are immunizations current? ❑ Yes ❑ No			

ALLERGIES	
	Reaction:
	Reaction:
	Reaction:

SURGERIES		
Year	Reason	Hospital

OTHER HOSPITALIZATIONS		
Year	Reason	Hospital

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS (VITAMINS, INHALERS)			
Name the Drug	Strength	Frequency Taken	Indication

SOCIAL HISTORY					
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	How much do you drink per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No

PAST MEDICAL HISTORY – please check if you have or ever had any of the following

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

- □ Alcoholism
- □ Anemia
- □ Anticoagulation therapy
- □ Anxiety
- □ Arthritis
- □ Artificial heart valve
- □ Artificial joints (i.e. knee, shoulder)
- □ Asthma
- □ Auto immune disease
- □ Blood transfusion
- □ Cancer
- □ Chemotherapy
- □ Cataracts
- □ Cirrhosis
- □ Colon polyps
- □ Congestive heart failure
- □ Coronary artery disease
- □ Crohn's disease
- □ Deep vein thrombosis
- □ Depression
- □ Diabetes mellitus
- □ Drug dependence
- □ Epilepsy
- □ Fibromyalgia
- □ GERD (heartburn)
- □ Heart disease
- □ Hepatitis B
- □ Hepatitis C
- □ High cholesterol
- □ High blood pressure
- □ HIV/AIDS positive
- □ Inflammatory bowel disease
- □ Irritable bowel syndrome
- □ Kidney disease
- □ Liver Disease
- □ Mental disease
- □ Myocardial Infarction (Heart Attack)
- □ Organ Transplant
- □ Osteoporosis
- □ Pacemaker
- □ Pancreatitis
- □ Rashes/ Skin Problem
- □ Sexually Transmitted Disease
- □ Sickle Cell Anemia
- □ Sleep Apnea
- □ Thyroid Disease
- □ Tuberculosis
- □ Ulcerative Colitis
- □ Other:_____

For women only:

- □ Are you/possibly pregnant?

FAMILY HEALTH HISTORY

Please check id any member of your family (i.e. spouse, children, parents, siblings) has every had any of the followings:

- □ Allergies
- □ Autoimmune disease
- □ Cancer
- □ Diabetes mellitus
- □ Heart disease
- □ Hepatitis B
- □ Hepatitis C
- □ High cholesterol
- □ High Blood Pressure
- □ Other: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Guardian signature *Date*