Dr's Powell and Fredrickson

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial:_____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial:_____

Address: _____ Address 2: _____

City, State, Zip: _____

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:_____ 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. ☐ Text

Section 2 Section 3

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Pref. Pharmacy: _____

Primary Insurance Information

Name of Insured:_____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec:_____ Insured Birth Date: _____

Employer:_____ Ins. Company:_____

Address:_____ ID #:_____

Address 2:_____ Group #:_____

City, State, Zip:_____ _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ ID #: _____

Address 2: _____ Group #: _____

City, State, Zip: _____ _____

Medical History

Dental History

Who can we thank for referring you to our office? _____

What would you like us to do today? _____

Are you in dental pain today? _____

Who was your former Dentist? _____

What was the approx. date of your last dental treatment? _____

Check yes or no if you have had the following:

Bleeding Gums	○ Yes ○ No	Scaling/Root Planing ("Deep Cleaning")	○ Yes ○ No
Clicking or Popping Jaw	○ Yes ○ No	Food Collection Between Teeth	○ Yes ○ No
Grinding or Clenching	○ Yes ○ No	Loose Teeth or Broken Fillings	○ Yes ○ No
Sensitivity to Cold	○ Yes ○ No	Sensitivity to Hot	○ Yes ○ No
Sensitivity to Biting	○ Yes ○ No	Sores or Growths in the Mouth	○ Yes ○ No

How do you feel about the appearance of your teeth? _____

Have you ever had an adverse reaction during a dental proceedure? ○ Yes ○ No If yes _____

Is there anything else that we should know about your dental history? ○ Yes ○ No If yes _____

Primary Care Physician

Name _____

Phone _____

Date of Last Visit _____

Are you currently under physician care? ○ Yes ○ No If yes _____

Women

Are you pregnant? ○ Yes ○ No

Are you nursing? ○ Yes ○ No

Are you taking birth control pills? ○ Yes ○ No

Medical History

Have you ever used a bisphonsphonate medication? ○ Yes ○ No

Brand names include: Fosamax, Actonel, Atelvia.

Have you ever had a blood transfusion? ○ Yes ○ No If yes _____

Have you had any serious illness or operations in the last 12 months? ○ Yes ○ No If yes _____

Have you had any of the following?

AIDS/HIV	○ Yes ○ No	Anaphylaxis	○ Yes ○ No	Arthritis	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No
Angina	○ Yes ○ No	Asthma	○ Yes ○ No	Blood Disease	○ Yes ○ No	Cancer	○ Yes ○ No
Chemical Dependent	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Circulatory Problems	○ Yes ○ No	Persistent Cough	○ Yes ○ No
Diabetes	○ Yes ○ No	Epilepsy	○ Yes ○ No	Fainting	○ Yes ○ No	Headaches	○ Yes ○ No
Hemophilia/Abnormal Bleeding	○ Yes ○ No	Herpes	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Pacemaker	○ Yes ○ No
Psychiatric Care	○ Yes ○ No	Radiation Treatment	○ Yes ○ No	Respiratory Disease	○ Yes ○ No	Shingles	○ Yes ○ No
Shortness of Breath	○ Yes ○ No	Stroke	○ Yes ○ No	Surgical Implants	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Tonsillitis	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Ulcer	○ Yes ○ No	Colitis	○ Yes ○ No

History of Hepatitis? ○ Yes ○ No If yes _____

History of Heart Problems? ○ Yes ○ No If yes _____

History of Kidney Disease or Malfunction? ○ Yes ○ No If yes _____

History of Liver Disease? ○ Yes ○ No If yes _____

Do you have any artificial joints? ○ Yes ○ No If yes _____

Allergies

Are you allergic to any antibiotics? ○ Yes ○ No If yes _____

Are you allergic to any pain medications? ○ Yes ○ No If yes _____

Are you allergic to Latex? ○ Yes ○ No If yes _____

Do you have any other known allergies? ○ Yes ○ No If yes _____

Please List All Current Medications:

Authorization

Signature of Patient, Parent or Guardian:

X _____ Date: _____