A.Q. Denture & Implant Center
Registration Information

Date: _____

Patient's name: _____Home Phone: _____Cell Phone: _____

Address: _____City_____State_____Zip_____

Previous address if less than 3 years: _____

Birthdate: _____ Social Security number: _____

Please circle one: Single Married Widowed Divorced Separated

Employed by: _____ Phone: _____

Address: _____City_____State_____Zip_____

How long employed? _____Position: _____

Spouse Name: _____ Cell or home phone: _____

Spouse Birthdate: _____ Social Security number: _____

Spouse Employed by: _____ Phone: _____

In Case of emergency: _____ Phone: _____

Who is responsible for this account? _____ Relationship: _____

Please provide any/all insurance cards; we will make copies for your records.

DENTAL INSURANCE INFORMATION

Insured Name _____

Insurance Co. _____

Address _____

Provider Phone _____

Insured Employer _____

Group/Policy # _____

MEDICAL INSURANCE INFORMATION

Insured Name _____

Insurance Co. _____

Address _____

Provider Phone _____

Insured Employer _____

Group/Policy # _____

DENTAL HISTORY

1. Do you wear Dentures? …… YES NO
   If yes, Uppers _____Lowers _____ for how long? _____
2. Do you wear Partials? …… YES NO
   If yes, Uppers _____Lowers _____ for how long? _____
3. Are you experiencing any discomfort or pain at this time? …… YES NO
   If yes, where is pain? _____
4. Are you satisfied with the appearance of your teeth at this time? ……..YES NO
5. Are you able to eat and chew food satisfactorily? ……YES NO
6. Do you have headaches, ear aches, neck pain? ……..YES NO
7. Do you frequently experience sinus problems? ……YES NO
8. Have you had any serious trouble associated with previous dental treatment? YES NO
   If yes, explain: _____

GENERAL MEDICAL HISTORY

The following information has a direct bearing on your dental health. Circle **YES** or **NO** for each of the questions below. **All information is personal and confidential.**

Sex: _____ Height: _____ Weight: _____ Age: _____ Race: _____

9. Are you in good health? …… YES NO
10. Has there been any change in your general health within the last year? YES NO
11. Approximate date of last physical examination? …….. YES NO
12. Are you under a physician's care? ……. YES NO
    If yes, for what condition? _____
13. Have you been hospitalized or had a serious illness within the past (5) years? YES NO
    If yes, for what condition? _____

Physician name: _____ Phone: _____

ALLERGIES

1. Are you allergic or have had an adverse reaction to any of the following?
   a. Local anesthetics……. YES NO
   b. Antibiotics, Penicillin, Sulfa Drugs…….. YES NO
   c. Barbiturate, Sedatives, Sleeping Pills…… YES NO
   d. Aspirin…… …… YES NO
   e. Iodine ……YES NO
   f. Codeine or other Narcotics …….. YES NO
   g. Other ……YES NO
2. Do you have Asthma or Hay Fever…… YES NO
3. Do you or have you ever had Hives or Skin Rash …… YES NO

MEDICATIONS

1. Are you taking any of the following medications? If yes, please list below.
   a. Antibiotics or Sulfa Drugs? _____ YES NO
   b. Anticoagulants? _____ YES NO
   c. Medicine for High Blood Pressure? _____ YES NO

MEDICATIONS CONTINUED …

d. Codeine or other Narcotics? _____ YES NO
e. Tranquilizers? _____ YES NO
f. Other? _____ YES NO

BONE JOINTS

1. Do you have any of the following?
   a. Arthritis …….. YES NO
   b. Inflammatory Rheumatism ……... YES NO
   c. Bone Infection ……. YES NO
   d. Osteoporosis…….. ……. YES NO

CARDIOVASCULAR SYSTEM

1. Do you have or have had any of the following:
   a. Heart attack …… YES NO
   b. Stroke ……..…….. YES NO
   c. Coronary Insuffiency …… YES NO
   d. Damaged Heart Valves ……YES NO
   e. Congenital Heart Disease ……YES NO
   f. Rheumatic Heart Disease ……YES NO
   g. Chest pain after exertion? …… YES NO
   h. Shortness of breath after mild exercise? ……YES NO
   i. Do your ankles swell? …… YES NO
   j. Do you have any blood pressure problems?.....YES NO

   HIGH _____ LOW _____

CENTRAL NERVOUS SYSTEM

4. Do you have or have you ever had any of the following?
   a. Epilepsy …… YES NO
   b. Fainting spells …….. YES NO
   c. Seizures …… YES NO
   d. Emotional disturbances …… YES NO
5. Do you follow any treatment for a nervous disorder? …… YES NO

DIGESTIVE SYSTEM

1. Do you have or have you ever had any of the following?
   a. Stomach Ulcers…… YES NO
   b. Hepatitis …….. YES NO
   c. Jaundice …… YES NO
   d. Liver Disease…… …… YES NO
2. Have you ever vomited blood? …… YES NO
3. Do you have any diarrhea? …….. YES NO

ENDOCRINE SYSTEM

1. Do you have Diabetes? ……YES NO
2. Does anyone in your family have diabetes? …… YES NO
3. Do you urinate more than 6 times a day? ……. YES NO
4. Are you often thirsty or do you have a dry mouth? …….. YES NO
5. Do you have Hypothyroidism or Hyperthyroidism? ……. YES NO

GENITOURINARY SYSTEM

6. Do you have or have you ever had any of the following?
   a. Kidney Trouble……. YES NO
   b. Syphilis, Gonorrhea…….. YES NO
   c. AIDS ……. YES NO

HEMOGLOBIN

1. Do you have Anemia, Sickle Cell Disease, Blood Disorder? ……. YES NO
2. Is there any family history of blood disorders? ……. YES NO
3. Are you hemophilic? ……. YES NO
4. Have you had abnormal bleeding after surgery, extraction or trauma? …….. YES NO
5. Have you had a blood transfusion? ……... YES NO

NEOPLASM

1. Do you have or have you ever had any of the following?
   a. Tumor or Malignancy …… YES NO
   b. Chemotherapy or Radiations Therapy ……YES NO
2. Are you regularly exposed to x-rays or any other ionizing radiation or toxic substances? ……... YES NO
3. Do you have Glaucoma? ……YES NO
4. Are you wearing or do you wear contact lenses? …….. YES NO
5. Do you drink alcohol?.....YES NO
   If yes, how often? _____
6. Do you smoke or use tobacco?.....YES NO
   If yes, how often? _____

RESPIRATORY SYSTEM

1. Do you have a persistent cough or cold? …….. YES NO
2. Do you have or have you had Tuberculosis? ……YES NO
3. Is there any history of Tuberculosis in your family? ……YES NO
4. Do you have sinusitis or sinus issues? ……...YES NO
5. Do you Emphysema, Chronic Bronchitis, Asthma? ……..YES NO

Do you have any disease, condition or problem not listed above that you think we should know about to be able to give you the best care?

Please explain: _____