DENTAL IMPLANT CENTER OF ROYAL OAK

Patient Registration

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

Sex: **M** **F** Marital Status: **S** **M** **D** **W** Date of Birth: _____ Age: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Social Security #: _____

Employer: _____ Position: _____ Primary Physician: _____

Pharmacy: _____ Cross Streets or Phone Number: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Dental Insurance: **Y** **N** (if no, please skip to medical history)

Company: _____ Name of Insured: _____ Relationship: _____

Insured Birth Date: _____ Insured Employer: _____ ID #: _____

Medical History

Y **N** Do you consider yourself to be in good medical health? Date of last medical check up: _____

Y **N** Are you taking ANY medications/vitamins (i.e. fish oil, etc.) If yes, please list: _____

_____

Y **N** Do you normally pre-medicate with ANTIBIOTICS prior to dental treatment? _____

Y **N** Are you currently being treated by a medical doctor? If so, for what? _____

Y **N** Have you ever had any injury to your face or jaw? If yes, please explain: _____

Y **N** Do you smoke or chew tobacco? How much? _____ **Y** **N** Do you consume alcohol? _____

Y **N** Are you allergic to or react to any medications/drugs/foods (i.e. penicillin, aspirin, codeine, lidocaine, latex, peanuts, etc.)? If so, please list: _____

Y **N** Do you use recreational drugs (i.e. cocaine, etc.)? _____

Y **N** Are you ever short of breath with mild exertion? Please explain: _____

Y **N** Have you been hospitalized recently? Why? _____ When? _____

Y **N** Have you had any surgeries within the past year? _____ When? _____

Have you ever had any of the following?

Y **N** Heart Disease (valve replacement, bypass, pacemaker, mitral valve prolapse, heart murmur, stent, angioplasty, etc.)

Y **N** Epilepsy or Seizures

Y **N** Blood Pressure: HIGH LOW

Y **N** Cancer

Y **N** Ulcers

Y **N** Diabetes

Y **N** Glaucoma

Y **N** Kidney Disease

Y **N** Bleeding Problems (inability to clot)

Y **N** AIDS or HIV

Y **N** Hepatitis A B C

Y **N** Are you pregnant?

Y **N** Lung Disease (TB, COPD, asthma, emphysema, etc.)

Y **N** Rheumatic Fever

Y **N** Radiation Treatments

Y **N** Arthritis

Y **N** Sinus Trouble

Y **N** Joint Replacement - HIP KNEE OTHER: _____

Y **N** Psychiatric Treatment

Y **N** Liver Disease

Y **N** Blood Disease (anemia, leukemia, sickle cell)

Y **N** Blood Thinners (Plavix, Coumadin, Xarelto, Eliquis)

Y **N** Are you taking any contraceptives?

Y **N** Are you taking any Osteoporosis medications (i.e. Fosamax, Boniva, Prolia)

Please describe any other medical or dental treatment that the doctor should know about._____

_____

_____

Patient/Guardian Signature: _____ Date: _____ Doctor Signature: _____