Lightpoint Dental

REGISTRATION FORM / MEDICAL-DENTAL HISTORY

PATIENT REGISTRATION FOR: _____

Residence Address	
Telephone	Referred By
Other Family Members in the Practice	Preferred Time for Appointments
SSN - -	DOB / /
Marital Status S M D W	Spouse's Name
If Minor, Name of Guardian	Address & Telephone
Person Responsible for Fee (if other than patient)	Relationship to Patient
Billing Address (if different from above)	
Occupation	Will you receive calls at work? ☐ Yes ☐ No
Employer's Name & Telephone	
EMERGENCY NOTIFICATION Name & Telephone	

Medical Alert Sticker

INSURANCE INFORMATION

	Primary Carrier	Secondary Carrier
Name of Insurance Company		
Address		
Telephone		
Subscriber's Name/ Relationship to Patient	/	/
Name of Group Policyholder or Union		
Group Policy # / Individual Policy #	/	/
Effective Date	/	/

Lightpoint Dental

REGISTRATION FORM / MEDICAL-DENTAL HISTORY page 2

Medical History

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

1. Name, address & phone # of your physician _____
2. Date of last visit to your doctor _____ Purpose of visit _____
3. Do you suffer from any disability?_____ If yes, describe _____

_____

_____

_____

4. Do you have AIDS, or are you HIV-positive? _____ If yes, describe and provide current status. _____

_____

5. Have you ever had, or do you now have hepatitis? _____ If yes, describe. _____
6. For females: Are you pregnant?_____ If yes, when are you due?_____
7. For females: Are you taking birth control pills? _____ *Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*
8. Are you taking any drugs or medications?_____ If yes, list and describe amounts and purpose. _____

_____

_____

_____

_____

_____

_____

_____

Note: There are many drugs and medications when mixed with other drugs and/or medications may cause complications, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.

9. Have you ever had an allergic reaction to medication?_____ If yes, describe._____
10. Have you lost weight recently? _____ If yes, describe. _____

Have You Ever Had Or Been Treated For:

11. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? _____

_____

12. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? _____

Lightpoint Dental

REGISTRATION FORM / MEDICAL-DENTAL HISTORY page 3

Medical History [continued]

13. Stomach or intestinal disease?_____

14. Abnormal blood pressure, excessive bleeding, or anemia?_____

15. Breathing problems, asthma, tuberculosis, or hay fever? _____

_____

16. Cancer, X-ray treatments, or chemotherapy? _____

_____

17. Diabetes? _____

18. Kidney problems or renal dialysis? _____

19. A stroke, convulsions, or fainting spells? _____

20. Tumors or growths? _____

21. Arthritis or rheumatism?_____

22. Have you ever had a major operation? _____ Is yes, describe. _____

_____

23. Have you ever had a serious injury to your head or neck? _____ If yes, describe. _____

_____

24. Do you smoke? _____ If yes, describe type and quantity._____

_____

25. Are there any other problems about your health of which you are aware? _____

_____

_____

26. Females: Are you currently taking any bisphosphonate medication?_____

27. Have you had any prosthetic joint replacement? _____

Dental History

1. Name of previous dentist_____ Date of your last visit _____

2. Reason for your last visit (or series of visits) _____

3. Do you have any of your X-rays or dental records? _____

4. Chief dental complaint if any?_____

In respect to any previous dental treatment have you:

5. Ever fainted? _____

6. Had an allergic reaction?_____

7. Had abnormal bleeding? _____

8. Any other complications during or following dental treatment? _____ If yes, describe. _____

_____

Lightpoint Dental

REGISTRATION FORM / MEDICAL-DENTAL HISTORY page 4

Dental History [continued]

9. Do your gums bleed on brushing or eating? _____
10. Does food catch between your teeth? _____
11. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? _____
12. Are any of your teeth sensitive to heat, cold, or pressure? _____
13. Do you grind your teeth or clench your jaws? _____
14. Do you have pain or clicking in the jaw joint in front of your ear? _____
15. Have your jaw muscles ever been sore? _____ If yes, describe. _____
16. Are there any sores or growths in your mouth? _____
17. Do any of your teeth ache? _____
18. Do you have any other dental complaint? _____

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or health practitioners.

Person completing the form: _____ Signature _____

Print Name _____

If other than patient, indicate relationship _____ Date ____/____/____

Dentist's History Review & Significant Findings _____

Signature Dr. _____ Date ____/____/____