

# SPRINGFIELD LORTON DENTAL GROUP

## ADULT REGISTRATION FORM

LAST NAME		FIRST NAME		MI	SSN
DOB	GENDER: M / F	MARITAL STATUS: S / M / D / W		NAME OF SPOUSE	
ADDRESS					
CITY		STATE	ZIP		
HOME PHONE		CELL PHONE		WORK PHONE	
EMPLOYER				POSITION	
SPOUSE'S EMPLOYER				SPOUSE'S WORK PHONE#	
PHYSICIAN			PHONE#	CITY/STATE	
EMERGENCY CONTACT			EMERGENCY PHONE #		
REFERRED TO OFFICE BY:			YOUR E-MAIL ADDRESS:		

### MEDICAL HISTORY:

Y	N	CONDITIONS	Y	N	CONDITIONS	Y	N	CONDITIONS
		ABNORMAL BLEEDING			GLAUCOMA			STROKE
		ALCOHOL ABUSE			HIV+ AIDS			THYROID PROBLEMS
		ALLERGIES			HAY FEVER			TUBERCULOSIS
		ANEMIA			HEART ATTACK			ULCERS
		ANGINA PECTORIS			HEART MURMUR			YELLOW JAUNDICE
		ARTHRITIS			HEART SURGERY	Y	N	<b>ALLERGIES</b>
		ARTIFICIAL BONES			HEMOPHILIA			ASPIRIN
		ARTIFICIAL HEART VALVE			HEPATITIS A			CODEINE
		ASTHMA			HEPATITIS B			DENTAL ANESTHETICS
		BLOOD TRANSFUSION			HEPATITIS C			ERYTHROMYCIN
		CANCER-CHEMOTHERAPY			HIGH BLOOD PRESSURE			JEWELRY
		COLITIS			KIDNEY PROBLEMS			LATEX
		CONGENITAL HEART DEFECT			LIVER DISEASE			METALS
		COSMETIC SURGERY			LOW BLOOD PRESSURE			PENICILLIN
		DIABETES			MITRAL VALVE PROLAPSE			TETRACYCLINE
		DIFFICULTY BREATHING			PREMED	OTHER ALLERGIES:		
		DRUG ABUSE			PACE MAKER			
		EMPHYSEMA			PAIN IN JAW JOINTS	Y	N	
		EPILEPSY			PSYCHIATRIC PROBLEMS			DO YOU SMOKE OR USE TOBACCO?
		FAINTING SPELLS			RHEUMATIC FEVER			<b>FEMALES ONLY:</b>
		FEVER BLISTERS			SEIZURES			ARE YOU PREGNANT OR NURSING?
		FREQUENT HEADACHES			SINUS PROBLEMS			ARE YOU TAKING BIRTH CONTROL PILLS?

PLEASE LIST ALL MEDICATIONS THAT YOU ARE PRESENTLY TAKING:

IS THERE ANY DISEASE,CONDITION OR PROBLEM THAT YOU THINK THIS OFFICE SHOULD KNOW ABOUT THAT IS NOT COVERED ABOVE?

HAVE YOU EVER HAD ANY BAD EXPERIENCES AT THE DENTAL OFFICE?

IS THERE ANYTHING THAT YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE?

### OFFICE POLICIES AND CONSENT FOR TREATMENT

BEFORE TREATMENT CAN BE RENDERED, ADEQUATE RADIOGRAPHS OF THE TEETH AND MOUTH MUST BE TAKEN.

WE USE LOCAL ANESTHETIC AND OTHER METHODS OF PAIN CONTROL TO MAKE OUR PATIENTS MORE COMFORTABLE WHILE RECEIVING DENTAL TREATMENT.

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, CONSENT TO THE PERFORMING OF THE DENTAL AND ORAL SURGICAL PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE, AND I WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THOSE PROCEDURES.

THIS IS TO CERTIFY THAT I WAS GIVEN A COPY OF SPRINGFIELD LORTON DENTAL GROUP NOTICE OF PRIVACY PRACTICES

PRINT YOUR NAME:

SIGNATURE:

DATE: