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	REFERRED TO OFFICE BY:

HOME PHONE	WORK PHONE	CELL PHONE

YOUR E-MAIL ADDRESS:	EMPLOYER

SPOUSE'S EMPLOYER	SPOUSE'S WORK #	SPOUSE'S CELL #

PHYSICIAN	PHONE#	CITY/STATE

EMERGENCY CONTACT	EMERGENCY PHONE #	PHARMACY #

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**	**ALLERGIES**
		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			**FEMALES ONLY:**
		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:

HAS ANYONE EVER TOLD YOU THAT YOU SNORE? Y / N

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

HAVE YOU EVER TAKEN ANY BISPHOSPHONATES MEDICATIONS (such as Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, Zometa or Reclast)? Y / N

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

INSURANCE INFORMATION

Sponsor's Name	Sponsor's DOB	Sponsor's SSN

PRINT YOUR NAME:

SIGNATURE:	DATE:

For Office Use Only: Entered by _____ Checked by _____ WL by _____