

**Richard B. Derksen D.M.D., M.S.
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Patient Registration Form**

Today's Date _____

Patient's Name Mr/Dr/Mrs/Ms _____

Birthdate _____ Social Security Number _____ Sex _____

Address _____ City, State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail Address _____

() Single () Married () Divorced () Widowed () Employed () Unemployed () Full-time student () Part-time student

Employer _____ Work Phone _____ Ext _____

Patient's Relationship to responsible party () Self () Spouse () Child

If patient is NOT the responsible party, please fill out the following additional information:

Responsible Party Mr/Dr/Mrs/Ms _____

Address _____ City, State _____ Zip _____

Social Security Number _____ Birthdate _____ Home Phone _____

Employer _____ Work Phone _____ Ext _____

Dental concerns you wish to discuss at today's appointment _____

Referred by _____ Name of previous dentist _____

Date of last dental visit _____ Have you had dental x-rays taken in the past year? _____

Medical History

Do you have any general health problems? () yes () no Explain _____

Physician's Name _____ Phone Number _____ Last Physical Exam _____

Emergency Contact _____ Phone number _____

Are you currently under a physician's care for any condition? () yes () no If yes, please explain _____

Please list all current medications, vitamins, and supplements and the conditions for which you are taking them: _____

Are you allergic to any medications or anesthesia? () yes () no LIST _____

List any hospitalizations in the last five years: _____

Please complete the remainder of the health history information on the reverse side.

Turn 

Has your physician/cardiologist/orthopedist ever recommended that you pre-medicate with antibiotics before your dental appointment? () yes () no If yes, please explain _____

Are you taking or have you ever taken bisphosphonate drugs, typically given to treat osteoporosis, by mouth or IV? () yes () no If yes, please explain _____

Do you take a blood thinner? () yes () no

Are you allergic to latex? () yes () no

Are you allergic to any type of metal? () yes () no

Do you currently use tobacco products? () yes () no

Have you used tobacco products in the past? () yes () no

() Cigarettes () Cigars () Smokeless Tobacco. Quantity used per day: _____ Years of use: _____

If you request nitrous for any procedures, please provide height and weight: _____

Do You Have or Have You Ever Had

	Yes	No		Yes	No
Abnormal Heart Condition	_____	_____	Tuberculosis	_____	_____
Artificial valve or vascular graft	_____	_____	A positive tuberculosis test	_____	_____
Asthma	_____	_____	Stroke	_____	_____
Arthritis	_____	_____	High Blood Pressure	_____	_____
Blood Transfusion	_____	_____	Low Blood Pressure	_____	_____
Steroid Use	_____	_____	Heart Transplant	_____	_____
HIV+, ARC, AIDS	_____	_____	Vertigo	_____	_____
Epilepsy	_____	_____	Sinus Problems	_____	_____
Osteoporosis	_____	_____	Sexually Transmitted Disease	_____	_____
Infective Endocarditis	_____	_____	Kidney Trouble	_____	_____
Emotional Disorder	_____	_____	Liver Problem	_____	_____
Chemo/Radiation	_____	_____	Bleeding Disorder	_____	_____
Oral Contraceptives	_____	_____			
Diabetes/A1C	_____	_____	Type	_____	
Are you pregnant/breastfeeding	_____	_____	Due Date	_____	
Cancer	_____	_____	Type and date	_____	
Hepatitis	_____	_____	Type and date	_____	
Use of Oral appliance or CPAP	_____	_____	Type	_____	

I certify that the information on the previous page and above is complete and correct _____

Patient Signature

In our practice, many patient photos are taken for the purposes of communicating with our laboratory, recordkeeping and for use in educational presentation. Please initial below to indicate your consent to the use of photography of your mouth for the purposes of education and advancement of dentistry. Pictures shown are only of the teeth and oral cavity, and do not reveal the identity of the subject. _____

Initials