

98 East Main Street
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Laser Periodontics and Implants

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Periodontal Aesthetics & Advanced Regeneration

PATIENT REGISTRATION

Name _____

Spouse's Name _____

D.O.B. ___/___/___ Age _____

Emergency Phone Number and contact person

Social Security # _____

Home Address _____

Whom may we thank for referring you to our practice?

City _____ State _____ Zip _____

Years at Address _____ Rent or Own _____

Dentist's Name _____

Email Address _____

Address _____

Home Phone _____

Phone _____ Date of last exam _____

Business Phone _____

Physician's Name _____

Cell _____

Address _____

Which telephone would be best for messages? _____

Phone _____ Date of last exam _____

Occupation _____

Findings? _____

Employer Name _____

What is your present problem and what would you like to have handled today?

Years at Employer _____

Marital Status (circle one) S M W D

DENTAL INSURANCE

So that we may assist you in submitting dental insurance claims, please complete ALL of the following information:

Primary Holder _____

Secondary Holder _____

D.O.B. ___/___/___ Social Security # _____

D.O.B. ___/___/___ Social Security # _____

Employer _____

Employer _____

Name _____

Name _____

Address _____

Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Insurance Carrier _____ Group # _____

Insurance Carrier _____ Group # _____

Insurance Co. Address _____

Insurance Co. Address _____

Phone _____

Phone _____

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY

These questions all have relevance to your oral health. They will help and protect you. Please complete each item.

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>1. Have you been hospitalized in the past? Yes No
Why? _____</p> <p>2. Have you been under the care of a medical doctor in the past 5 years? Yes No
Why? _____</p> <p>3. Have you been sick in past 3, 6, 9, 12 months? Yes No</p> <p>4. Have you taken any medicine or drugs in the past 2 years? Yes No
What? _____</p> <p>5. Do you take aspirin daily or any nutritional supplements or vitamins? Yes No
What? _____</p> <p>6. Are you allergic to, or made sick by any medication or drug? Yes No
What? _____</p> <p>7. Have you ever had excessive bleeding requiring special treatment? Yes No</p> <p>8. Have you ever been told to take antibiotics before dental care? Yes No</p> <p>9. Do you have chest pain, shortness of breath or loss of strength walking upstairs? Yes No</p> | <p>10. Do your ankles swell during the day? Yes No</p> <p>11. Have you lost or gained more than 10 pounds in the past year? Yes No</p> <p>12. Are you on a special diet? Yes No</p> <p>13. Do you have any disease or problem not listed? Yes No</p> <p>14. Women: Are you or might be pregnant now or anticipate becoming pregnant? Yes No
Are you taking birth control pills or any hormone medication? Yes No</p> <p>15. Have you had recent life events that have resulted in stress or tension? Yes No</p> <p>16. Do you smoke? Yes No How Much _____</p> <p>17. Do you exercise regularly? Yes No</p> <p>18. Have you ever taken Fosamax (Alendronate), Actonel (Risedronate), Boniva (Ibandronate), Aredia (Pamidronate), Zometa (Zoledronate), Skelid (Tiludronate), Etidronate (Didronel), Fen-phen? Yes No
If yes, when did you start the medication? _____</p> <p>19. Have you ever had breast cancer, prostate cancer or multiple myeloma and been treated for the spread of these cancers to the bone or have you ever had Paget's disease? Yes No</p> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Please check any of the following which you have had or do have

- | | | | | |
|--------------------------------------------------|------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes (also in the family) | <input type="checkbox"/> HIV | <input type="checkbox"/> Epilepsy or Seizure |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Fainting/Dizzy Spells |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> X-ray or Cobalt Therapy | <input type="checkbox"/> Hepatitis B (Serum) | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Cancer, Leukemia | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Canker Sores |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Cough | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Drug Addiction | |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hemophilia | |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea) | |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cold Sores | |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Sinus Trouble | | | |

Comments _____

1. To the best of my knowledge, all of the answers I have given on this form are true and correct. If I ever have a change in my health, or if my medications change, I will inform Dr. Scharf at my next visit.
2. I authorize Dr. Scharf or designated staff to take models, x-rays, photographs or any other diagnostic materials deemed appropriate by Dr. Scharf to diagnose and document my oral condition. I understand that Dr. Scharf lectures nationally and internationally and is actively involved in publication. I consent to the use of the materials for teaching or publication purposes and understand that my identity will be protected.
3. Upon such diagnosis, I authorize Dr. Scharf to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care. I understand that where appropriate, credit bureau reports may be obtained.

Date _____

Signature _____

Reviewed by _____

Date _____