## Frank L. Higginbottom, D. D. S. Richard B. Derksen D.M.D., M.S. Kimberly Higginbottom Fesler, D. D. S. 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 PhoneE-r	nail 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	BirthdateHome I	Phone
Employer	Work Phone	Ext
	day's appointment	
	Name of previous dentist	
Date of last dental visit	Have you had dental x-rays taker	n in the past year?

### **Medical History**

Physician's Name	Phone Number	_ Last Physical Exam
Emergency Contact	Phone number	
Are you currently under a physic	cian's care for any condition? yes no If yes, please	explain
Are you currently under a physic	cian's care for any condition? yes no If yes, please	explain
	cian's care for any condition? yes no If yes, please	•

Has your physician/cardiologist/orthopedist ever recommended that you pre-medicate with antibiotics before dental procedures for the following conditions:

History of Infective Endocarditis	VAC	no		
Thistory of Infective Endocardins	yes	no		
Artificial heart valves	yes	no		
Congenital heart conditions	yes	no		
Heart transplant	yes	no		
Artificial Joints(Knee, Hip, Shoulder, etc.)	yes	no		
Are you allergic to latex? yes no	Are you a	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 pe	er day:	Years of use:	_	
Are you taking or have you ever taken bisphosphonate drugs, typically given to treat osteoporosis, by mouth or IV?				
These drugs include: Fosamax, Boniva, Actonel, Skelid, Didronel, Aredia, Zometa and Bonefos. yes no				

#### Do You Have or Have You Ever Had

	Yes	No	Yes	No
Abnormal Heart Condition		Tuberculosis		
Heart Murmur		A positive tuberculosis test		
Mitral valve prolapse	20	Prosthetic Joints		
Artificial valve or vascular graft		High Blood Pressure		
Rheumatic Fever		Low Blood Pressure		
HIV+, ARC, AIDS		Prolonged Bleeding		
Epilepsy		Cortisone or Steroids in last	t 6 mo	
Diabetes		Туре		
Are you pregnant		Due Date		
Cancer		Type and date		
Hepatitis		Type and date		
Venereal Disease		Type and date		

Thank you for completing this form. We will have you sign below in our office.

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