Frank L. Higginbottom, D. D. S.
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 (__)Widow (__)Employed (__)Unemployed (__)Full-time student (__)Part-time student

Employer_________________________________ Work Phone _______________Ext _______

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

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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		
Infective Endocarditis			Disease 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