ANDREW R. GALL, DDS
Adult Registration Form

Date_____

Patient_____
First name **Middle initial** **Last name** **Preferred name**

Street address_____

City, State, Zip code _____

Phone numbers:

Home_____**Work**_____**Cell**_____

Email address for appointment verification and reminders:

_____

Male_____ **Female**_____ **Age:** _____ **Birth date**_____

Social security number_____

Employer_____ **Occupation**_____

Employer address_____

Spouse name_____ **Spouse birth date**_____

Spouse social security number_____

Spouse employer_____**Occupation**_____

Dental Insurance Information (if applicable):

Employer who carries policy_____

Name of dental insurance company _____

Dental insurance company claim address_____

Group number for policy_____

Social Security number of policyholder_____

Birth date of policyholder_____

In case of emergency, who should be notified? _____

Who may we thank for referring you? _____

Adult Medical History

Name of your physician_____

Do you have any ALLERGIES to:
Medications: Yes_____ No_____ If yes, please list_____
Anesthetics: Yes_____ No_____ If yes, please list_____
Other (seasonal, food, etc.)_____
_____
Please list all medications you are taking (**PRESCRIPTION** *AND* **OVER THE COUNTER**) (inc. inhalers)
_____
_____
_____
_____

HEART-Please check any that apply to you

___Artificial heart or valves
___History of heart infection
___Irregular heart beat
___High blood pressure

HEALTH-Please check any that apply to you

____***Joint replacement*** surgery If yes, what and when?_____
____Anxiety/panic disorder
____Seizures
____Respiratory problems (asthma)
____Persistent swollen neck glands
____Problems with mental health or nervous problems
____Cancer
____Problems with immune system
____Abnormal bleeding
____Hepatitis, liver disease
____Tuberculosis
____Stomach ulcer or acid reflux
____Diabetes
____AIDS or HIV positive
____Sexually transmitted disease
____Treatment for tumor or growth
____Do you consume alcohol on a regular basis?
____Do you now or have you ever used tobacco products? When did you quit?_____
____Do you currently use drugs recreationally or have a past history of drug use?

Have you had any serious problems associated with previous dental treatment?
_____
Do you have any other condition or health problem not listed here?_____
_____

<u>Women:</u>
____Are you pregnant or do you suspect you are pregnant?
____Are you nursing?
____Are you taking birth control? (certain antibiotics, aspirin products, and antacids may interfere with the reliability of oral contraceptives and other precautions may need to be taken)

_____ _____
Patient signature Date

Andrew R. Gall, DDS
Adult Dental History

Patient name_____

Please check any that apply:
___Is there anything about your teeth or smile you would change?
___Are you apprehensive about dental treatment?
___Do you gag easily?
___Does food catch between your teeth?
___Do you have difficulty with chewing?
___Do your gums bleed when you floss?
___Are your teeth sensitive?
___Do your jaws make a bothersome noise?
___Do you frequently clench or grind your teeth?
___Do you have headaches or pain when you awake?
___Do you take medication for pain or discomfort?
___Do you wear a night guard?
___Have you ever had gum surgery?
___Are you familiar with dental implants?

How often do you brush your teeth?_____
How often do you floss your teeth?_____
Date of last dental visit?_____

_____
Patient signature Date

OFFICE USE ONLY **Medical History Update:**

_____

_____

_____

_____

_____