ALAMO DENTALHEALTH
Change Your Smile, Change Your Life.
8647 Wurzbach Rd., Bldg B San Antonio, TX 78240
210.691.1211 Fax 210.697.0829 newsmiles@adhsa.com

DENTAL REGISTRATION

PATIENT INFORMATION

Date _____ Social Security # _____

Name (First) _____ (Middle) _____ (Last) _____

Address _____ City _____ State _____ Zip _____

E-mail _____ Sex ☐M ☐F Age _____ Birthdate _____

☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered

Patient's Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home _____ Cell _____ Work _____ (Ext) _____

Best time and place to reach you _____ Spouse's phone _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Peridontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

Sleep Quality Screening

How likely are you to **doze off or fall asleep** in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale choose the most appropriate number for each situation: **0** = no chance **1** = slight chance **2** = moderate chance **3** = high chance

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Total points _____

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Health History

Patient Name _____ **Date** _____

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine, Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Do you wear contact lenses?	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Fainting or Dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
			Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			

Women:

Are you pregnant? ☐ Yes ☐ No Due date: _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

_____

Pharmacy _____ Phone _____

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____

Patient's Signature _____ Doctor's Signature _____

FOR FUTURE UPDATES ONLY

Has there been any change in your health since your last dental appointment? Yes No Date of update: _____

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Any other changes to your health or well-being? _____

Patient's Signature _____ Doctor's Signature _____