Patient Registration Form

Dental Practice Dr. G. Onodi

Dear Patient, Please fill out this form to the best of your ability. Our practice will then immediately process it and return to you an estimate. Once you have filled out this form, you can fax it to us at: +1(954)575-1151. You can alternatively e-mail the completed form to registration@germanydent.com.

1 - Contact Information

First Name _____ Last Name _____ Middle _____

Birthdate _____ Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ Zip Code _____ email _____

Country _____

2 - Dental History

Date of last dental visit _____

Date of last cleaning _____

Date of last full-mouth X-Rays _____

Please describe your dental problems. Please be as specific as you can.

Are any of your teeth sensitive to:
- ☐ Hot or cold?
- ☐ Biting or chewing?
- ☐ Sweets?
- ☐ Have you noticed any mouth odors or bad tastes?
- ☐ Do you frequently get cold sores, blisters or any other oral lesions?

Your gums:
- ☐ Do your gums bleed or hurt?
- ☐ Have you noticed any loose teeth or change in your bite?

Do you:
- ☐ Bite your lips or cheeks regularly?
- ☐ Clench or grind your teeth while awake or asleep?
- ☐ Smoke or chew tobacco?

Have you ever had:
- ☐ A bite plate or a mouth guard?
- ☐ Serious injury to head or mouth?
- ☐ Oral surgery?
- ☐ Periodontal treatment?
- ☐ Orthodontic surgery?

Have you ever experienced:
- ☐ Headaches, neck aches or shoulder aches?
- ☐ Pain? (joint, ear, side of face)
- ☐ Difficulty in chewing on either side of the mouth?
- ☐ Clicking or popping of the jaw?
- ☐ Difficulty in opening or closing the mouth?
- ☐ Sore muscles?

Do you feel anxious about dental treatment? If yes, what is your concern?

Have you ever had an upsetting dental treatment?

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3 - Medical History

Your physician's name:

Physician's Phone

Are you taking any medications? ◯ Yes ◯ No

If yes, please list:

Are you aware of any allergic/ adverse reactions? ◯ Yes ◯ No

If yes, please list:

Have you been a patient in the hospital in the past five years? ◯ Yes ◯ No

If yes, for what reason?

Have you been under the care of a medical doctor in the past two years? ◯ Yes ◯ No

If yes, for what condition?

Please indicate which of the following you had or have at present:

- ☐ Artificial joints (Hip, Knee, etc)
- ☐ Diet (special/ Restricted)
- ☐ Swollen Ankles
- ☐ Arthritis/ Rheumatism
- ☐ Ulcers
- ☐ Diabetes
- ☐ A.I.D.S
- ☐ Emphysema
- ☐ Heart Murmur
- ☐ Stroke
- ☐ Rheumatic Fever
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ High Blood Pressure
- ☐ Chronic Cough
- ☐ Congenital Heart Disease
- ☐ Chest Pain
- ☐ Heart (Surgery, Disease, Attack)
- ☐ Kidney Trouble
- ☐ Thyroid Problems
- ☐ Glaucoma
- ☐ Contact Lenses
- ☐ Tuberculosis

Please indicate which of the following you had or have at present:

- ☐ Neurological Disorders
- ☐ Hemophilia
- ☐ Blood Transfusion
- ☐ Yellow Jaundice
- ☐ Hepatitis A (infectious) B (serum)
- ☐ Radiation Therapy
- ☐ Hay Fever
- ☐ Nervous/ Anxious
- ☐ Bruise Easily
- ☐ Cold Sores/ Fever Blisters
- ☐ Venereal Disease
- ☐ Liver Disease
- ☐ Tumors
- ☐ Sinus Trouble
- ☐ Epilepsy or Seizures
- ☐ Psychiatric/ Psychologic Care
- ☐ Sickle Cell Disease
- ☐ Cortisone Medicine
- ☐ H.I.V. Infection
- ☐ Hepatitis C
- ☐ Chemotherapy
- ☐ Latex Allergy
- ☐ Fainting or Dizzy Spells
- ☐ Asthma

Do you have any disease/ condition not listed above? Please list:

Women Only:

- ☐ Taking birth control?
- ☐ Nursing?
- ☐ Are you pregnant?

Signature _____ Date _____

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