Patient Registration

David C. Daughters D.D.S. Inc.
763 Academy Drive
Solana Beach, Ca. 92075

Please complete the following:

Today's Date: _____

(please circle) Dr. Mr. Mrs. Miss Ms

Last Name:_____ First Name: _____ M.Int: ___

Age:_____ Birthdate:_____ Soc. Sec. # _____

Address:_____

Number Street City State Zip

Home Phone #_____ Cell Phone # _____ E-Mail _____

Bus. Phone #_____ Employer : _____ Occupation:_____

Marital Status: _____ Parent's name & Phone # (if Minor): _____

Spouse's Name (if applicable): _____ _____

Whom may we thank for referring you? _____

Insurance Information: (If you have Dental Insurance, please complete the following.)

Name of Insurance Company: _____ Group # _____

Name of Primary Insured: _____ ID # _____

Primary Insured Date of Birth: _____ & Soc. Sec. # _____

If Full Time Student Status applies: _____ _____

Name of School City & State of School

Medical Health History:

General Health (please circle) **Excellent** **Good** **Fair** **Poor**

Height: _____ Weight: _____ Date of last Physical? _____

Are you taking any Medication now? _____ , if yes for what purpose? _____

List of current Medications: _____

_____

Are you sensitive or allergic to: Penicillin___ Codeine___ Local Anesthetics___ Other Medications ?_____

- ☐ Have you gained or lost weight within the last year ? ..... Yes _____ No _____
- ☐ Have you ever been treated (other than diagnostic) with radiation/x-ray?..... Yes _____ No _____
- ☐ Are you subject to prolonged bleeding ? ..... Yes _____ No _____
- ☐ Are you subject to fainting spells ?..... Yes _____ No _____
- ☐ Do you have excessive urination and/or thirst ? ..... Yes _____ No _____
- ☐ Do your wear contact lenses ? ..... Yes _____ No _____
- ☐ Do you smoke ?..... Yes _____ No _____
- ☐ Do you drink alcoholic beverages ? ..... Yes _____ No _____
- ☐ Are you Pregnant ? ..... No _____ Yes _____ how many Months ? _____

Medical Health History (Cont.)

Have you ever been treated for:

Heart Disease..... Yes____ No ____
Rheumatic Fever..... Yes____ No ____
Abnormal Blood Pressure.....Yes ____ No ____
Ulcers.....Yes ____ No____
Tuberculosis or Lung disease.....Yes ____ No ____
Diabetes.....Yes ____ No ____
Epilepsy.....Yes ____ No ____
Anemia.....Yes ____ No ____
Congenital Heart Lesions.....Yes ____ No ____
Tumor or Growth.....Yes ____ No ____
Thyroid Problems.....Yes ____ No ____
Low Blood Sugar.....Yes ____ No ____

Heart Murmur.....Yes ____ No____
Jaundice.....Yes ____ No ____
Asthma or Hay Fever.....Yes ____ No____
Sinus trouble.....Yes ____ No ____
Cough.....Yes ____ No ____
Hepatitis.....Yes ____ No ____
Arthritis.....Yes ____ No ____
Had a Stroke.....Yes ____ No ____
Glaucoma.....Yes ____ No ____
Nervous Disorders.....Yes ____ No ____
Kidney Disease.....Yes ____ No ____
Fainting or Dizziness.....Yes ____ No ____

Do you have any disease, condition or problem not listed above that you feel I should know about? Yes ____ No ____

If yes, please explain: _____

_____

_____

Name of Physician :_____ Phone # _____

Dental Health:

Reason for visit:_____

When was your last Dental Visit ? _____ When were your Teeth last X-Rayed ? _____

Have you ever had any serious problem associated with previous dental treatment ?.....Yes ____ No ____

If so, please explain : _____

_____

Have you ever been treated for Gum Disease ? (Deep Scaling/Root Planing/Tissue Grafting).....Yes ____ No ____

How many times a day do you brush your Teeth ? _____ How often do you floss ? _____

What texture toothbrush do you use ? SOFT ____ MEDIUM ____ HARD ____ NYLON ____ NATURAL ____

Do your gums bleed when you Floss or Brush ?.....Yes ____ No ____

Do you feel pain in any of your Teeth when you Floss or Brush ?.....Yes ____ No ____

Do your gums feel tender or swollen ?.....Yes ____ No ____

Do you know of any growths or sore spots in your mouth ?.....Yes ____ No ____

Do your Teeth ever have twinges of pain ?.....Yes ____ No ____

If yes, list anything that causes the pain:_____

_____

Do you clench or grind your Teeth while sleeping or during the day ?.....Yes ____ No ____

If you've had Orthodontic Treatment (Braces) how long ago was treatment done ? _____

Do you wear any removable Partials or Full Dentures ?.....Yes ____ No ____

Do you gag easily ?.....Yes ____ No____

Have you ever had any problems "getting numb" for Dental treatment ?.....Yes ____ No ____

Please add anything you feel is important:_____

_____

_____

Patient's Signature :

_____