

# PATIENT REGISTRATION

Timothy J Houlihan Jr. D.M.D.

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

First Middle Last  
SS# \_\_\_\_\_ DL# \_\_\_\_\_ Occupation \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Spouses Name: \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_ Zip \_\_\_\_\_

Home Number (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Pager #(\_\_\_\_) \_\_\_\_\_

Fax # (\_\_\_\_) \_\_\_\_\_ E- Mail Address \_\_\_\_\_

Employer Name and Address \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_ Relationship \_\_\_\_\_

Social Security # \_\_\_\_\_ DL# \_\_\_\_\_ Home # (\_\_\_\_) \_\_\_\_\_

Home Address (if different) \_\_\_\_\_ Zip \_\_\_\_\_

Employer & Address \_\_\_\_\_

Occupation \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_

Referred By \_\_\_\_\_ Physician \_\_\_\_\_

Do you have Dental Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ With Whom? \_\_\_\_\_

Nearest Relative Not Living With You \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Are you currently having dental problems? \_\_\_\_\_

What are your concerns? *Circle as many as applicable:* (Pain Avoidance) (Appearance) (Losing Teeth) (Gum/Periodontal Disease) (Cavities) (Oral Cancer) (Wasting/Exceeding Dental Insurance Limits) (Your General Health) (Routine Checkup) (Cleaning) (Other \_\_\_\_\_)

How important is your dental health to you? Low 1 2 3 4 5 6 7 8 9 10 High

What would you rate your **current** dental health? Low 1 2 3 4 5 6 7 8 9 10 High

If you could change your smile you would: *Circle as many as applicable:* (Brighter Smile), (Straighten), (Repair chipped teeth), (Replace Missing Teeth), (Close the Gaps), (Replace old crowns that don't match), (Replace black metal fillings with natural tooth-colored fillings).

How do you feel about dental treatment? *Circle choices:* (Relaxed), (Uneasy), (Tense), (Anxious), (Very Anxious), (Major Phobia)

Select the following drugs you have used at any time: (Fosamax), (Aredia), (Zometa), (Actonel), (Didronel), (Boniva), (Skelid), (Bisphosphonate)

Are you allergic to any of the following? *Circle choices:* (Aspirin), (Penicillin), (Latex), Local Anesthetic), (other) \_\_\_\_\_

## Do you have or ever had:

- |  |     |    |
|--|-----|----|
| 1. Heart Problems or Chest Pain.....       | Yes | No |
| 2. Artificial heart valve or stent.....    | Yes | No |
| 3. Emphysema, Lung Disease, COPD.....      | Yes | No |
| 4. Hepatitis, Liver Trouble, Jaundice..... | Yes | No |
| 5. Asthma or hay fever?.....               | Yes | No |
| 6. Tuberculosis.....                       | Yes | No |
| 7. Diabetes? How long.....                 | Yes | No |
| 8. Kidney trouble?.....                    | Yes | No |
| 9. Glaucoma (Narrow angle or other).....   | Yes | No |
| 10. Thyroid trouble or goiter?.....        | Yes | No |
| 11. Syphilis?.....                         | Yes | No |
| 12. Fainting or dizziness?.....            | Yes | No |
| 13. Joint Replacement? How Long? .....     | Yes | No |
| 14. Arthritis?.....                        | Yes | No |
| 15. HIV AIDS?.....                         | Yes | No |
| 16. Stroke?.....                           | Yes | No |
| 17. Stomach ulcer?.....                    | Yes | No |
| 18. Heart murmur?.....                     | Yes | No |
| 19. Prostate trouble?.....                 | Yes | No |
| 20. Epilepsy or convulsions?.....          | Yes | No |
| 21. Anemia, leukemia or low platelets..... | Yes | No |
| 22. Psychiatric treatment?.....            | Yes | No |
| 23. Are you pregnant?.....                 | Yes | No |

## Are you now taking:

- |                                      |     |    |
|--------------------------------------|-----|----|
| 1. Drugs for high blood pressure?    | Yes | No |
| 2. Drugs for sleep?                  | Yes | No |
| 3. Cortisone, steroids or ACTH?      | Yes | No |
| 4. Anticoagulants or blood thinner?. | Yes | No |
| 5. Tranquilizers or sedatives?       | Yes | No |
| 6. Antibiotics?                      | Yes | No |
| 7. Insulin?                          | Yes | No |
| 8. Have you ever taken Fen-Phen?     | Yes | No |
| 9. Others?                           | Yes | No |
| 10. List any questions: _____        |     |    |

11. Have you been under the care of a physician for any major illness or injury other than those noted above. If so, list.

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I will pay today by: CASH  CHECK  CREDIT CARD

I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

Signature \_\_\_\_\_ Date \_\_\_\_\_