DRS. SCANNELL AND HOLLINGER, INC.
Patient Registration & Medical History Form

Patient Name: _____ Male/Female/Other _____ Date of Birth: _____/_____/_____

Guardian Name if under 18: _____Relationship to patient & phone #: _____

Emergency Contact if over 18: _____ Relationship to You & Phone #: _____

Home Phone :(_____)_____ Work :(_____)_____ Cell:(_____)_____

Mailing Address: _____ City, State & Zip: _____

E-Mail Address: _____ Preferred Contact Method: _____

Preferred Pharmacy Name: _____ Pharmacy Phone Number: _____

MEDICAL HISTORY & MEDICATIONS

Are you now under the care of a physician? _____ Physician's Name: _____

Please explain: _____

Do you take any blood thinner medications? YES ___ NO ___ If yes, type: _____

Are you presently taking, or have you ever taken any of the following bisphosphonate medications? (**Please circle**)

Etidronate (Didronel) Nisedronate (Actonel) Zoledronate (Zometa) Pmidronate (Aredia)

Ibandronate (Boniva) Tiludronate (Skelid) Zoledronic Acid (Reclast) Alendronate (Fosomax)

RANK Ligand Inhibitos: Denosumab (Xgeva, Prolia)

List any other prescription and/or over-the-counter drugs you are taking: _____

WOMEN ONLY: Are you taking Birth Control Pills? YES ___ NO ___ Are you pregnant? YES ___ (#Weeks ____) NO ____ Are you Nursing? YES ___ NO ____

Are you allergic to any of the following? (**Please circle**)

Aspirin Codeine Dental Anesthetics Erythromycin Latex Penicillin Tetracycline Jewelry Metals Seaweed Sulfa

Other Allergies? Please List: _____

Do you use tobacco? YES ___ NO ____ If YES, frequency _____

Do you have or have you had any of the following? (**Please circle all that apply**)

Anemia	Chemotherapy	Fever Blisters/Herpes	HIV/AIDS/Hepatitis	Arthritis	High/Low Blood
Shingles	Anxiety with Dental Visits	Cobalt	Glaucoma	Stroke	Rheumatic Fever
Depression	Sinus Problems	Thyroid Problems	Kidney Problems	Liver Problems	Sleep Apnea
Diabetes	Heart Murmur	Ulcers	Heart Attack	Artificial Joints	Lupus
Tuberculosis	Psychiatric Issues	Artificial Valves	Opthalmic Eye Surgery	Cold Sores	Congenital Heart Defect
Mitral Valve Prolapse		Asthma/ Difficulty Breathing			
Back Problems		Drug/Alcohol Abuse	Hemophilia/Abnormal Bleeding		
Cancer/RadiationTx		Epilepsy/Convulsions	Pressure Severe Headaches		

Do you have any artificial joints and/or a medical condition that would require antibiotic Pre-Medication? YES ___ NO ___
Please Specify: _____
Date of Joint Replacement (approx): _____ Surgeon's Name: _____

Name of Previous Dentist: _____ Date of Last Visit: _____

What was done at that time? _____

Why have you come to the dentist today? _____

Are you currently experiencing dental pain or discomfort? YES ___ NO _____

If YES, please explain: _____

How many times per day do you brush? _____ Floss? _____ Do you use a hard, medium, or soft brush? _____

For the following questions please circle. Y = YES; N = NO; or S = SOMETIMES

Do your gums bleed when you brush or floss? Y N S	Do you have earaches or neck pains? Y N S
Are your teeth sensitive to cold, hot, sweets, or pressure? Y N S	Do you have any jaw clicking, popping, or discomfort? Y N S
Is your mouth dry? Y N S	Do you brux or grind your teeth? Y N S
Have you had any periodontal (gum) treatments? Y N S	Do you have sores or ulcers in your mouth? Y N S
Have you ever had orthodontic treatment? Y N	Do you wear dentures or partials? Y N S
Have you had any problems with previous dental treatment? Y N	Have you ever had a serious head or mouth injury? Y N S
Is your home water supply fluoridated? Y N	Do you like your smile? Y N S

Primary Dental Insurance:

Policy Holder Name: _____ Employer: _____

Subscriber ID: _____ Social Security #: _____ Date of Birth: _____

Primary Dental Insurance Company: _____ Group #_____

Secondary Dental Insurance:

Policy Holder Name: _____ Employer: _____

Subscriber ID: _____ Social Security #: _____ Date of Birth: _____

Primary Dental Insurance Company: _____ Group #_____

AUTHORIZATION FOR TREATMENT: I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any change in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____ Date:_____ Doctor Signature:_____Date:_____

Drs. Scannell And Hollinger,Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin , age, disability, or sex.