PATIENT REGISTRATION

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Responsible Party is also a Policy Holder for Patient					
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			.00		

Patient Name:

FLORESTA PLAZA DENTAL Eaglesoft Medical History

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physicial	an's care now?		⊕ Yes €) No	If yes				
Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-Fen or Redux? Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?		O Yes O No		If yes					
		Yes @) No	If yes					
		○ Yes ○ No		If yes					
		en or Redux?	Yes No		If yes				
		Actonel or	O Yes	No	If yes				
Are you on a special die		ospiionatesr	O Voc 6	No					
			Yes No						
Do you use tobacco?			⊕ Yes €) No					
Vomen: Are you									
Pregnant/Trying to g	et pregnant?		Nursing	?			Taking or	ral contraceptives?	
re you allergic to any of t	he following?								
Aspirin		Penicillin			4	Codeine		Acrylic	
Metal		Latex				Sulfa Drugs		Local Anesthetics	
Other?					If yes				
	.heteneed			No					
Do you use controlled su	ibstances		Yes €) NO	If yes				
o you have, or have you	had, any of the	following?							
AIDS/HIV Positive	O Yes O No	Cortisone Me	dicine	Yes		Hemophilia	Yes No	Radiation Treatments	Yes
Alzheimer's Disease	Yes No	Diabetes		Yes	⊕ No . .	Hepatitis A	O Yes O No	Recent Weight Loss	Yes
Anaphylaxis	O Yes O No	Drug Addictio	in	Yes	No	Hepatitis B or C	Yes No	Renal Dialysis	O Yes O N
Anemia	Yes No	Easily Winder	1	Yes	⊘ No	Herpes	O Yes O No	Rheumatic Fever	O Yes ON
Angina	Yes No	Emphysema		Yes	⊚ No	High Blood Pressure	O Yes O No	Rheumatism	O Yes O N
Arthritis/Gout	Yes No	Epilepsy or S	eizures	@ Yes	⊚ No	High Cholesterol	Yes No	Scarlet Fever	⊕ Yes ⊕ N
Artificial Heart Valve	Yes No	Excessive Ble		Yes	⊚ No	Hives or Rash	Yes No	Shingles	O Yes O N
Artificial Joint	Yes No	Excessive Thi		Yes	⊚ No	Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes O N
Asthma	Yes No	Fainting Spells		Yes	Direction 1	Irregular Heartbeat	Yes No	Sinus Trouble	O Yes O N
Blood Disease	Yes No	Frequent Cou		Yes	1	Kidney Problems	O Yes O No	Spina Bifida	Yes N
Blood Transfusion	Yes No	Frequent Dia		Yes		Leukemia	O Yes O No	Stomach/Intestinal Disease	⊕ Yes ⊕ N
Breathing Problems	O Yes O No	Frequent Hea		⊚ Yes	2 12 14	Liver Disease	Yes No	Stroke	O Yes O N
Bruise Easily	O Yes O No	Genital Herpe		Yes		Low Blood Pressure	Yes No	Swelling of Limbs	Yes O N
[편설명] 보고 그래요 하고 보고 있다.	O Yes O No	The second second		⊚ Yes	7		Yes No		O Yes O N
Cancer	Yes No	Glaucoma		O Yes		Lung Disease	O Yes O No	Thyroid Disease	O Yes O N
Chemotherapy	Yes No	Hay Fever	- 1			Mitral Valve Prolapse	and the second	Tonsillitis	
Chest Pains	-	Heart Attack/		O Yes	The second second	Osteoporosis	O Yes O No	Tuberculosis	Yes ON
Cold Sores/Fever Blisters		Heart Murmu		⊕ Yes		Pain in Jaw Joints		Tumors or Growths	Yes N
Congenital Heart Disorder		Heart Pacema		O Yes	The state of the state of	Parathyroid Disease	○ Yes ○ No	Ulcers	Yes N Yes N
Convulsions	Yes No	Heart Trouble	e/visease	Tes	O INO	Psychiatric Care	Yes No	Venereal Disease Yellow Jaundice	O Yes O N
Have you ever had any s	serious illness n	ot listed	⊘ Yes €	No	If yes			1	
omments:									

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: