Cape Cod Perio • Specialists in Periodontics and Dental Implants

Patient Registration

Today's Date:_____

Name:

_____

I prefer to be called:

_____

Home Mailing Address:

_____

_____

City State Zip Code

Birth Date:_____

S.S. #:_____

Primary Phone:_____

Secondary Phone:_____

Mobile Phone:_____

E-mail:_____

Employer:_____

Address:_____

_____

Occupation:_____

Present Dentist:_____

Previous Dentist:_____

Dental Coverage: Yes _____ No _____

Name of Dental Insurance Company:

_____

Is your dental insurance in the name of Spouse / Parent?
Spouse / Parent Name:

_____

Spouse / Parent Employer:

_____

Spouse / Parent Birth Date:

_____

Spouse / Parent S.S.#:

_____

Please give us your dental insurance card(s) to copy.

In the event of an emergency, whom may we contact?
Name:

_____

Relationship:

_____

Primary Phone:

_____

Secondary Phone:

_____

Mobile Phone:

_____

Medical History:
Physician's Name:_____

Phone:_____

Date of last visit:_____

Reason:_____

What pharmacy do you regularly use and what town?

_____

Please continue to next page...

Are you required by a physician to premedicate for all dental appointments? Yes _____ No _____

If yes, what antibiotic are you prescribed? _____

Your physical health is: Good _____ Fair _____ Poor _____

Are you currently under the care of a physician? Yes _____ No _____

Are you taking any prescription/over the counter medications? Yes _____ No _____

Please list: _____

_____

Have you ever taken bisphosphonate? Yes _____ No _____

Do you smoke? Yes _____ No _____ If yes, how often _____

For Women: Are you taking birth control pills? Yes _____ No _____

Are you pregnant? Yes _____ No _____

Have you ever had any of the following conditions? Please check all that apply.

- ❏ Abnormal Bleeding
- ❏ Alcohol/Drug Abuse
- ❏ Arthritis
- ❏ Artificial Joints/Valves
- ❏ Asthma
- ❏ Cancer/Chemotherapy
- ❏ Colitis
- ❏ Congenital Heart Defect
- ❏ Diabetes
- ❏ Emphysema
- ❏ Epilepsy
- ❏ Fainting Spells
- ❏ Frequent Headaches
- ❏ Glaucoma
- ❏ Heart Attack
- ❏ Hemophilia
- ❏ Hepatitis
- ❏ Herpes/Fever Blisters
- ❏ High Blood Pressure
- ❏ HIV/AIDS
- ❏ Hospitalized for any reason
- ❏ Kidney Problems
- ❏ Liver Disease
- ❏ Low Blood Pressure
- ❏ Mitral Valve Prolapse
- ❏ Pacemaker
- ❏ Psychiatric Problems
- ❏ Radiation Treatment
- ❏ Rheumatic/Scarlet Fever
- ❏ Seizures
- ❏ Shingles
- ❏ Sickle Cell Anemia
- ❏ Stroke
- ❏ Thyroid Problems
- ❏ Ulcers
- ❏ Anything Else?_____

Are you allergic to any of the following? Please check all that apply.

- ❏ Aspirin
- ❏ Codeine
- ❏ Latex
- ❏ Dental Anesthetics
- ❏ Penicillin
- ❏ Erythromycin
- ❏ Tetracycline

Anything Else?_____

_____

I have reviewed and completed all of the information on this Patient Registration Form. I declare the information I have supplied to be true and correct to the best of my knowledge and will notify you of any changes in the above information. I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered, regardless of my insurance status.

We will not use or disclose your health information except as outlined in our Notice of Privacy Practices. For a complete copy of our Notice of Privacy Practices, please ask any staff member.

Patient Signature _____ Date: _____

CAPE COD PERIO
244 Willow Street • Yarmouth Port, MA 02675
office 508.375.9090 • www.capecodperio.com