Cape Cod Perio • Specialists in Periodontics and Dental Implants

Patient Registration

Today's Date: ______________________

Name: ______________________

How do you wish to be addressed: ______________________

Home Mailing Address:

____

____

City State Zip Code

Birth Date: ______________________

S.S. #: ______________________

Primary Phone: ______________________

Mobile Phone: ______________________

Email: ______________________

May we leave messages on your phone regarding your appointment, treatment, etc. as needed:

Yes ________ No ________

Employer: ______________________

Occupation: ______________________

Present Dentist: ______________________

Previous Dentist: ______________________

DENTAL COVERAGE: Yes ________ No ________

WE NEED YOUR DENTAL INSURANCE CARD(S) TO COPY.

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 & Employer: ______________________

Spouse / Parent S.S.#: ______________________

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

Relationship: ______________________

Primary 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? ____________________

Do you take any anticoagulants (ex: coumadin, xarelto, aspirin, etc.)? Yes _________ No _________

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 (or give staff list): ____________________

____

Have you ever taken bisphosphonate (medication for treatment of osteoporosis)? 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: ____________________

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