



Patient Registration and Health History

Patient Legal First Name: _____

Permission to contact via (Circle): Home Cell Email

Patient Legal Last Name: _____

Contact Preference (Circle): Home Cell Email

Date of Birth: _____

Insurance Subscriber Name: _____

Preferred Name: _____

Subscriber Birthdate: _____

Title: Dr Mr Mrs Ms Miss Mx _____

Subscriber SS#: _____

Pronouns (Circle): He/Him She/Her They/Them

Relationship to Patient: _____

Gender at Birth (Circle): Male Female

Dental Insurance Name: _____

Gender Identification (Circle): Male Female Non-Binary

Group #: _____

Address: _____

Insurance Phone #: _____

Emergency Contact Name: _____

Email: _____

Phone: _____

SSN: _____

Pharmacy Name/Location/Phone #: _____

Home Phone: _____

Cell Phone: _____

How did you hear about us? _____

I certify that I, and/or my dependents have insurance coverage with the above-named insurance and assign directly to Scordakis Family Dental all insurance benefits. If any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Scordakis Family Dental may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature: _____

Date: _____

Print Name: _____

Relationship to Patient: _____

Dental History (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitive to biting |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Clench or grind teeth | <input type="checkbox"/> How often do you brush?
_____ |
| <input type="checkbox"/> Blisters on lips or mouth | <input type="checkbox"/> Swollen or tender gums | <input type="checkbox"/> How often do you floss?
_____ |
| <input type="checkbox"/> Burning tongue | <input type="checkbox"/> Lip or cheek biting | <input type="checkbox"/> List any other tools used
regularly? _____ |
| <input type="checkbox"/> Chew on one side only | <input type="checkbox"/> Loose or broken teeth | <input type="checkbox"/> When was your last dental
cleaning? _____ |
| <input type="checkbox"/> Smoker | <input type="checkbox"/> Mouth breather | <input type="checkbox"/> When was your last dental xrays?
_____ |
| <input type="checkbox"/> Recreational drugs (Marijuana,
etc) | <input type="checkbox"/> Orthodontic treatment | |
| <input type="checkbox"/> Jaw clicking or popping | <input type="checkbox"/> Periodontal treatment | |
| <input type="checkbox"/> Jaw/Mouth pain or tenderness | <input type="checkbox"/> Dental Implants | |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Sensitive to cold/hot | |
| | <input type="checkbox"/> Sensitive to sweet | |

HEALTH HISTORY

Height: _____ Weight: _____

Physician's Name & Medical Group: _____

Medical Record #: _____ Phone #: _____ Date of last visit: _____

Have you ever used bisphosphonate medications? (Fosamax, Actonel, Atelvia, Didronel, Boniva): Yes No

Have you ever taken immunotherapy medications for cancer? (Keytruda, Opdivo, Libtayo, Tecentriq, Bavencio, Imfinzi, Yervoy, Tivdak): Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-Phen"? (Ionimin, Adipex, Fastin, Pondimin, Redux): Yes No

Please check the box if you have had any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Swollen Feet/Ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Thyroid Issue |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Hepatitis Type | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Herpes | <input type="checkbox"/> Tumor or Growth on Head or Neck |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Jaundice | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Liver Disease | Women Only: |
| <input type="checkbox"/> Continental Heart Defect | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pregnant? Due Date: _____ |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Nursing? |
| <input type="checkbox"/> Cough (Persistent) | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Taking Birth Control |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Respiratory Disease | |

List of ALL current medication (Prescription, over the counter, vitamins, supplements, herbs, etc):

Allergies:

- | | | |
|---------------------------------------|---|--------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex | <input type="checkbox"/> Other |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Local anesthetic | _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | _____ |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa | _____ |

List any cognitive impairment / developmental delays (autism, ADHD, Dementia, etc): _____

List of all previous surgeries and serious illnesses (including dates):

Patient Signature: _____ Date: _____

Provider: _____