Metropolitan Dental Centers

PATIENT ACCOUNT NUMBER

PATIENT REGISTRATION

PATIENT'S LAST NAME	FIRST NAME	M. INITIAL	DATE OF BIRTH
STREET ADDRESS	CITY, STATE & ZIP		PHONE #'S
SEX □ MALE □ FEMALE	SOCIAL SECURITY NO.	DRIVERS LICENSE NO.	□ _____ (home) □ _____ (work) □ _____ (cell) Please check box beside preferred confirmation number.
Do you receive text messages on your cell? □ YES □ NO	EMAIL ADDRESS		
EMPLOYED BY		MARITAL STATUS □ SINGLE □ MARRIED □ SEPARATED □ DIVORCED □ WIDOWED	
BUSINESS ADDRESS		WHO WILL PAY THIS ACCOUNT (whose name is to appear on billing statement?)	
EMERGENCY CONTACT ADDRESS & PHONE (not at same address)		WHOM MAY WE THANK FOR REFERRING YOU? □ YELLOW PAGES □ INTERNET □ FRIEND/FAMILY □ OTHER _____	

SPOUSE'S LAST NAME	FIRST NAME	M. INITIAL	DATE OF BIRTH
STREET ADDRESS	CITY, STATE & ZIP		HOME PHONE
EMAIL ADDRESS	SOCIAL SECURITY NO	DRIVERS LICENSE NO.	WORK PHONE
EMPLOYED BY	MARITAL STATUS □ SINGLE □ MARRIED □ SEPARATED □ DIVORCED □ WIDOWED		CELL PHONE
BUSINESS ADDRESS	HOW LONG EMPLOYED _____ □ HOURLY □ SALARY □ RETIRED		

PRIMARY DENTAL INSURANCE CO.		MAILING ADDRESS	
GROUP #	SERVICE CODE	CONTRACT ID/ S.S. NO.	INS. CO. PHONE NO.

SECONDARY DENTAL INSURANCE CO.		MAILING ADDRESS	
GROUP #	SERVICE CODE	CONTRACT ID/ S.S. NO.	INS. CO. PHONE NO.

MEDICAL INS NAME Blue Cross Medicare Other _____	GROUP NO.
SUBSCRIBER NAME & DATE OF BIRTH	SERVICE CODE

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER

YES NO Is your general health good?
YES NO Has there been a change in your health within the last year?
YES NO Have you been hospitalized or had a serious illness in the last three years?
If YES, explain? _____
YES NO Are you being treated by a physician now? For what? _____
Physician's Name and Phone No. _____
YES NO Date of last Dental Exam _____
YES NO Are you in pain now? If YES, please explain _____

II. DO YOU HAVE OR HAVE YOU HAD: (If yes, please indicate by circling appropriate answer)

YES NO Heart disease, heart attack, pacemaker, prosthetic heart valve, or heart murmur?
If YES, please explain _____
Treating Physician's Name & Phone No. _____
YES NO Rheumatic fever?
YES NO Stroke, hardening of arteries?
YES NO High blood pressure?
YES NO Asthma, TB, emphysema, other lung disease?
YES NO Hepatitis, other liver disease?
YES NO Diabetes
YES NO Psychiatric care?
YES NO Tumors, cancer?
YES NO Radiation treatments or Chemotherapy?
YES NO Arthritis, rheumatism?
YES NO Artificial joint?
YES NO Osteoporosis?
YES NO Blood transfusions?
YES NO HIV/AIDS?
YES NO Thyroid, adrenal disease?
YES NO Kidney, bladder disease?
YES NO Herpes?
YES NO VD (syphilis/gonorrhea)?
YES NO Anemia?
YES NO Allergies to: **drugs, food, medications, latex, nickel**
If YES please list: _____

III. ARE YOU TAKING:

YES NO Tobacco in any forms?
If Yes, how much _____
YES NO Drugs, medications, over-the-counter medicines (including aspirin), natural remedies?
Please list: _____
YES NO Alcohol?
If Yes, how often _____
YES NO Recreational Drugs?

IV. WOMEN ONLY:

YES NO Are you or could you be pregnant or nursing?
YES NO Taking birth control pills?

V. ALL PATIENTS:

YES NO Is there anything else you think we should be aware of?
If Yes, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____

HEADACHE AND FACIAL PAIN SCREENING QUESTIONNAIRE

Name: _____ **Date:** _____

Temporomandibular Disorders are a frequent cause of headaches, facial pain and dental pain.
Please complete this screening questionnaire.

SYMPTOM CHECKLIST: Please check any of the following symptoms that apply to you. (L=left and R=right)

Headaches:

_____ Migraines _____ Tension Headaches _____ Other _____

How often? _____

Top of Head	_____ L	_____ R		Temples	_____ L	_____ R
Forehead	_____ L	_____ R		Behind Eyes	_____ L	_____ R
Back of Head	_____ L	_____ R		Pain in Shoulder	_____ L	_____ R
Pain in Head	_____ L	_____ R		Ear Congestion	_____ L	_____ R
Pain in Ear	_____ L	_____ R		Tinnitus (ringing in ears)	_____ L	_____ R
Dizziness (vertigo)	_____ L	_____ R		Facial Pain (non-specific)	_____ L	_____ R
Pain in Jaw Joint	_____ L	_____ R		Grating sound in joint	_____ L	_____ R

Clicking or popping in jaw joint _____ L _____ R

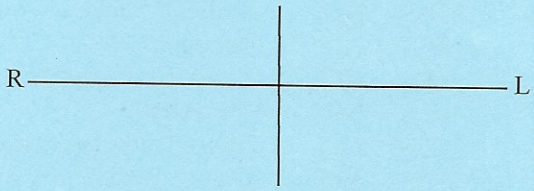
Partial inability to open mouth _____ No _____ Yes _____ Constant _____ Sporadic

Face muscle twitch _____ No _____ Yes

Difficulty swallowing _____ No _____ Yes

Difficulty breathing through nose _____ No _____ Yes

Difficulty chewing _____ No _____ Yes



Have you ever worn braces _____ No _____ Yes

Age when braces were on _____

Orthodontist _____

SLEEP APNEA EVALUATION

We have seen a recent increase of sleep apnea findings in our patients, which is a life threatening medical problem. To protect your health, we are asking you to complete the following screening form.

PLEASE ANSWER:

Do you snore? _____ No _____ Yes

$$BMI = \frac{W}{H^2\ (in)} \times 703 = \_\_\_\_\_$$

Are you excessively tired during the day? _____ No _____ Yes

Have you been told you stop breathing during sleep? _____ No _____ Yes

Do you have a history of hypertension? _____ No _____ Yes

Is your neck size greater than…….
17 inches (male)
16 inches (female) _____ No _____ Yes

YES to two or more of these questions is a positive screen for sleep apnea. If you answered yes to two or more questions, show this completed questionnaire to your doctor.