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 ☐ Other	SOCIAL SECURITY NO.	DRIVERS LICENSE NO.	☐ _____ (cell) ☐ _____ (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		
NAME AND ADDRESS OF PREVIOUS DENTIST	EMERGENCY CONTACT NAME/NUMBER		

RESPONSIBLE PARTY/SPOUSE	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

Responsible Party/SPOUSE LAST NAME	First Name		Date OF BIRTH
STREET ADDRESS	CITY, STATE & ZIP		HOME PHONE
EMAIL ADDRESS	SOCIAL SECURITY NO.	DRIVERS LICENSE	WORK PHONE
EMPLOYED BY	MARTIAL STATUS ☐ MARRIED ☐SINGLE ☐ SEPARARTED ☐ DIVORCED ☐ WIDOWED		CELL PHONE

WHOM MAY WE THANK FOR REFERRING YOU?

☐ INTERNET ☐ FRIEND ☐ FAMILY ☐ PATIENT ☐ OTHER _____

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 Allergies to: **drugs, food, medications, latex, nickel**
If YES please list_____

YES NO Anemia?
YES NO VD (syphilis/gonorrhea)?
YES NO Herpes?
YES NO Kidney, bladder disease?
YES NO Thyroid, adrenal disease?
YES NO HIV/AIDS?
YES NO Blood transfusion?
YES NO Osteoporosis?
YES NO Arthritis, rheumatism?
YES NO Artificial joint?
YES NO Headaches?

YES NO Jaw popping, clicking, or difficulty opening
YES NO Jaw pain, Dizziness, Difficulty chewing
YES NO Use of a CPAP Machine

YES NO Snoring
YES NO Excessively tired
YES NO Taking birth control pills
YES NO Pregnant or could be

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?

III. ALL PATIENTS:

YES NO Is there anything else you think we should be aware of?

If Yes, please explain: _____

IV: ALL PATIENTS: HAS ANY DOCTOR/PHYSICIAN EVER TOLD YOU THAT YOU NEED TO PRE-MEDICATE PRIOR TO ANY DENTAL APPOINTMENT?

YES NO If YES, please explain why and the name and phone number of that physician _____

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.

Please sign once must be 18 and over to sign

Patient Signature: _____ Date:_____

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

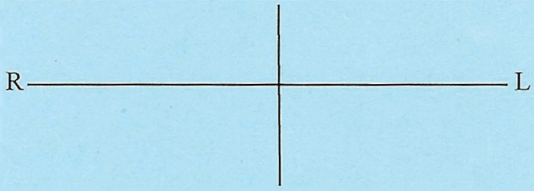
Partial inability to open mouth _____ No _____ Yes _____ Constant _____ Sporadic

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:

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

Do you snore? _____ No _____ Yes

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.