## Welcome to Pueblo Dental Center Patient Registration/Health History Form

## **Patient Information**

Name	Last	n	First			Middle	
		See:-1 See					
	rital Status: S M D W				DOB:	//	
Address							
City	State	Zip	Phone #		Cell #	Full Time	
	ployer Phone#						
Emergency Contac	et	Relati	onship	P	Phone #		
Pueblo Denta	k for your visit?Pho I Center on Valencia/Si						
Insurance Infe	y						
	Name						
Relationship to patient				-		_	
SUBSCRIBERS H	Employer						
Account Infor Person ultimately r	rmation responsible for account,	if not patient:					
Name	st						
						Middle	
	tient				Cell #		
Billing Address	Street			City	State	Zip	
Dental Inform							
Reason for today	's visit:Exam	_Emergency					
Are having pain of	or discomfort?yes	no For how	v long?				
Have you ever be appointments?	een instructed to take a _yesno If yes, ex	any medicatior	ns <u>or</u> take ANY sp	ecial precau	tions before a	ny dental	
HIPAA	nat you would like you						

Name

Relationship

## **Health Information and History**

DOB

Have you had any of the following?				
Yes No	Yes No		Yes No	
Do you have Active Tuberculosis?		Chemo/Radiation Treatment Coumadin Therapy (Eliquis, Plavix, Lovenox, Warfarin)		Mental Health Disorder
Have you had a persistent cough for		Diabetes Type		Mitral Valve Prolapse Osteoporosis
longer than 3 weeks, or produces blood?		Dry Mouth		Persistent swollen neck glands
**IF YOU ANSWER YES TO THE 2 ABOVE QUESTIONS PLEASE STOP NOW AND		Eating Disorders		
RETURN THIS FORM TO THE RECEPTIONIST!**		Epilepsy Fainting or Dizzy Spells		_ Respiratory Problems
Abnormal Bleeding		Glaucoma		Rheumatic Fever Sexual Transmitted Disease
AIDS/HIV Anemia		Heart Attack		C1 //C1 /
Anemia Angina		Heart Disease		Sinus Trouble
Arteriosclerosis		Heart Murmur		_ Sores/Ulcers in mouth
Artificial Heart Valve or		Hemophilia Hepatitis A, B, C		_ Stroke/Embolism
Heart Valve Replacement		High Blood Pressure		There : 1 Dec 1 1
Arthritis Asthma		Immunosuppression		Tubanaulasia
Blood Transfusion		Inborn Heart Defect		Ulcers/Gastric Reflux
Cancer Tumors		Jaundice, Liver Disease		Have you ever taken Phen-Fen?
		Kidney Problems		Sleep Apnea
Do your gums ble <sup>ed</sup> when you brush?	yesno	sometimes		
Do you have headaches, earaches				
Have you had any periodontal (gum) treat				
Do you wear removable dental appliances	s? yes	no		
Are your teeth sensitive tohot,cold		ts,pressure?none		
Do you have TMJ (jaw) problems?ye	es no			
Are you currently under the care of a phy	sician?			
If so, what is/are the condition(s) being	ng treated	?		
Physician Name		? Phone #		
		n? Or have had any serious illness or operati	on?	yesno
Have you had an orthopedic total joint (h If yes, which joint and when?		shoulder, elbow, finger) replacement?		
List all the medications that you are taking	ng or have	e recently taken:		
List an the metreations that you die taking	ing of have			
Are you taking or have ever been treated (Fosamax, Didronel, Skelid, Actonel, Boviva, An				
Are you allergic to the following? If so, Latexyesno Penicillin/Amoxic	, state read :illinye	ction sno <b>Aspirin</b> yesno <b>Codeine</b> ye	sno	
Please list any other known allergies (dru	ugs or oth	ers)		
Are you pregnant? Are you ta	king birth	control pills? Are you nursing?_		
I certify that I have read and understand the above. To set forth above have been answered to my satisfaction.	o the best of I will not hold tion of this for	<b>cuss any and all relevant patient health issues prior</b> my knowledge, all the information given is true and correct. I my dentist, or any other member of his/her staff, responsible m. I will inform the doctor if there are any future changes in m lures and the use of nitrous oxide gas and/or local anesthetic:	acknowled for any act y health or	ge that my questions, if any, about inquiries tion they take or do not take because of medications prior to any treatment.

released to my insurance company to facilitate processing my dental claim(s), and I agree to have the payment sent to Pueblo Dental Management, Inc. Patient agrees to pay for all dental services not paid by insurance coverage. If it becomes necessary to take action to collect any amount due, the prevailing party shall be entitled to recover collection costs, attorney's fees, court costs and the value of time lost by the dentist or any of his employees in preparation for/or participation in any collection action.

I understand there are no guarantees or warranties in health or dental care.

Signature of Patient			If Legal Representative, Print Name				Date	
MHR Date	Initials	*MHR Date	Initials	*MHR Date	Initials	*MHR Date	Initials	
MHR Date	Initials	*MHR Date	Initials	*MHR Date	Initials	*MHR Date	_Initials	

Rev. 07/2020 Patient Information - Adult Registration