DANIEL PETERSEN, DDS, INC.

Confidential Registration and Medical History

PATIENT INFORMATION

Patient Name:_____ Preferred Name:_____ Sex: ____M ____F

Date of Birth:_____SSN: _____ Home Phone:_____

Cell Phone:_____ Work Phone:_____ Name of Employer:_____

Mailing Address:_____ Zip Code: _____

☐Please check box if you prefer contact by Email:_____

Name of Dentist: _____Primary Care Physician:_____

Pharmacy: _____

RESPONSIBLE PARTY INFORMATION (IF PATIENT IS A MINOR)

Responsible Party Name:_____Relationship to Patient:_____

Address:_____ Zip Code:_____

Phone:_____ Date of Birth:_____ SS#:_____

INSURANCE INFORMATION

Dental Insurance Company:_____ Policyholder's Name:_____

Relationship to Patient:_____ SS#:_____ Date of Birth:_____

Member ID:_____ Group No.:_____

Name of Employer:_____ Employer Phone:_____

Secondary Insurance Company:_____ Policyholder's Name:_____

Relationship to Patient:_____ SS#:_____ Date of Birth:_____

Member ID:_____ Group No.:_____

Name of Employer:_____ Employer Phone:_____

Assignment and Release: I understand that I am financially responsible for all charges, whether or not paid by insurance. I, the undersigned, have insurance with _____ and assign directly to Daniel Petersen, DDS, all benefits, if any, otherwise payable to me for services rendered. I hereby authorize Daniel Petersen, DDS, to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date: _____ Signature:_____

CONFIDENTIAL HEALTH HISTORY

Please answer all questions by circling YES (Y) or NO (N)

1. Are you in good health? Y N
2. Have you had any serious illnesses, operations or hospitalizations? Y N
   If so, please describe:_____
   _____
   Height:_____ Weight:_____
3. **Do you have, or have you <u>ever</u> had (please <u>indicate which conditions</u> apply to you):**
   a. Rheumatic Fever or Rheumatic Heart Disease Y N
   b. Congenital Heart Disease Y N
   c. Cardiovascular Disease (heart trouble, heart attack, murmur, coronary artery disease, angina, stroke, palpitations, heart surgery or pacemaker placement)? Y N
   d. High Blood Pressure Y N
   e. Breathing Difficulty (asthma, emphysema, chronic cough, pneumonia, tuberculosis, or any other lung disorder)? Y N
   f. Snoring or Sleep Apnea Y N
   g. Fainting, dizziness, nervous disorders, seizures or epilepsy? Y N
   h. Bleeding Disorder (anemia, bleeding tendency, blood transfusion, bruise easily)? Y N
   i. Liver or Kidney Disease (Hepatitis, Jaundice)? Y N
   j. Herpes or MRSA skin infection? Y N
   k. Diabetes? Y N
   l. Arthritis? Y N
   m. Thyroid Disease (goiter)? Y N
   n. Stomach Ulcers or Colitis? Y N
   o. Glaucoma? Y N
   p. Mouth Sores (frequent or recurring)? Y N
   q. Implants placed in your body (knee, hip, etc.)? Y N
   r. Radiation treatment for cancer? Y N
   s. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grinding or clenching teeth? Y N
   t. Sinus or nasal problems? Y N
   u. Any disease, drug or operation that has depressed your immune system? Y N
4. **Are you using any of the following?**
   a. Antibiotics? Y N
   b. Anticoagulants (blood thinners)? Y N
      Please list:_____
   c. Aspirin, or drugs such as Aleve or Ibuprofen? Y N
   d. Blood Pressure medication? Y N
   e. Steroids (Cortisone, Prednisone, etc.)? Y N
   f. Tranquilizers (Valium, etc.)? Y N
   g. Insulin or other Diabetic medications? Y N
   h. Digitalis, Inderal, Nitroglycerin, or other heart medications? Y N
   i. Are you taking, or have you ever taken bisphosphonates (Fosamax, Actonel, Boniva for osteoporosis, or Zometa or Aredia for chemotherapy, etc.)? Y N
   j. Are you taking, or have you ever taken weight loss drugs (Phen-Fen, etc.)? Y N
   k. **<u>PLEASE LIST ALL MEDICATIONS TAKEN:</u>**
      _____
      _____
   l. **Are you a Pre-Med? Do You take an antibiotic before any dental procedures?** Y N
5. **Are you <u>ALLERGIC</u> to, or had an adverse reaction to:**
   a. Latex or rubber products? Y N
   b. Local Anesthetic (Novacaine, etc.) Y N
   c. Penicillin or other antibiotics? Y N
      Please list:_____
   d. Aspirin or Ibuprofen Y N
   e. Codeine or other pain killers? Y N
   f. Other allergies or reactions? Please list:
      _____
6. Do you smoke or chew tobacco? Y N
7. Do you currently use or have a history of using recreational drugs? Y N
8. Is there a past history of chemical dependency? Y N
9. Have you or an <u>immediate</u> family member had any problems associated with intravenous sedation? Y N
10. Do you have any other disease, condition or problem not listed that you think the doctor should be aware of? Y N
11. Do you wish to talk to the doctor privately? Y N
12. **For women only**:
    a. Are you pregnant, or is there any chance you might be pregnant? Y N
    b. Are you nursing? Y N

I understand the importance of a <u>truthful</u> Health History to Dr. Petersen in providing the best care possible and I will not hold my care providers responsible for any errors or omissions that I may have made. I have had the opportunity to discuss my Health History with Dr. Petersen. I certify that I have read and understand the above.

Date:_____ Signature:_____