Skees Family Dentistry
1370 Veterans Pkwy Ste 1500
Clarksville, In 47129

New Patient Registration

Patient Information

Name _____ Today's Date_____

Address_____ City _____ State _____ Zip _____

SSN# _____ Birthdate_____ Sex: M_____ F_____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Preferred Method of Communication: Phone ___ (H), (W), (C); Email ___ ; Text ____

Occupation _____ Employer _____

If you are completing this form for another person, what is your relationship to that person?_____

Please circle one of the following for each question below:

Y=Yes N=No DK=Don't Know

Do you have any of the following diseases or problems:

Active Tuberculosis? Y N DK
Persistent Cough greater than a 3 week period? Y N DK
Cough that produces blood? Y N DK
Been exposed to anyone with tuberculosis? Y N DK

If you answered yes to any of the above 4 questions, please stop and return this form to the receptionist.

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Emergency Information

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Insurance Information

Insured's Name _____

Insurance Company Name _____

Address _____ City _____ State _____ Zip _____

Insured's Employer _____ Group # _____

Insured's SS#_____ Insured's Birthdate _____

Dental History

Reason for Visit _____

Date of last dental visit _____ Date of last dental x-rays _____

What was done at that time?_____

Please circle one of the following for each question below:
Y=Yes N=No DK=Don't Know

Do your gums bleed when you brush or floss? ……..Y N DK
Are your teeth sensitive to cold, hot, sweets or pressure? ……..Y N DK
If yes, which of the above? _____

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Does food or floss catch between your teeth?.....Y N DK
Is your mouth dry?.....Y N DK
Have you had any periodontal (gum) disease? ……Y N DK
If yes, for how long? _____
Have you ever had orthodontic (braces) treatment?.....Y N DK
Have you had any problems with previous dental treatment? ……Y N DK
Is your home water supply fluoridated?.....Y N DK
Do you drink bottled or filtered water? ……Y N DK
Are you currently experiencing dental pain or discomfort? ……Y N DK
Do you have earaches or neck pains? ……...Y N DK
Do you have any clicking, popping or discomfort in the jaw? ……Y N DK
Do you brux or grind your teeth? ……Y N DK
Do you have sores or ulcers in your mouth?.....Y N DK
Do you wear dentures or partials? ……...Y N DK
Do you participate in active recreational activities? ……Y N DK
Have you ever had any serious injury to your head or mouth? ……..Y N DK
Are you apprehensive about dental treatment? ……Y N DK
If yes, then why? _____
Any other dental issues that your dentist may need to know?

_____

_____

Medical History

Are you now under the care of a physician? _____

Physician Name_____ Physician Phone Number _____

Address_____ City_____ State _____ Zip _____

Date of last Physician Visit _____ Reason _____

-Have you had a serious illness, operation or been hospitalized in the past 5 years? _____
If yes, what was it? _____

Please circle one of the following for each question below:
Y=Yes N=No DK=Don't Know
-Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? …….. Y N DK
Date: _____ If yes, have you had any complications? _____
Unless you have had the replacement in the last 2 years, antibiotic prophylaxis is no longer recommended
-Are you taking or scheduled to begin taking any medications for osteoporosis or Paget's disease?.....Y N DK
If yes, which one: alendronate (Fosamax®) or risedronate (Actonel®) or other?

-Since 2001, were you treated or are you presently scheduled to being treatment with the intravenous bisphosphonaes (Aredia® or Zometa®) for bone pain, hypercalcemia or

skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?.....Y N DK

-Date treatment began (begins) _____

-Do you use controlled substances (drugs)……Y N DK

-Do you use tobacco (smoking, snuff, chew, bidis)? ……Y N DK

If so, how interested are you in stopping? Very/Somewhat/Not interested

-Do you drink alcoholic beverages?.....Y N DK

If yes, how much alcohol did you drink in the last 24hrs_____

If yes, how much you typically drink in a week _____

WOMEN ONLY	
Are you pregnant?	Y N DK
If yes, number of weeks?_____	
Are you taking birth control pills or hormone replacement?	Y N DK
Are you nursing?	Y N DK

Are you allergic to or have any reaction to any of the following:
(If yes, specify the explain the type of reaction)

Local anesthetics_____ Y N DK

Aspirin_____ Y N DK

Penicillin or other antibiotics _____ Y N DK

Barbituate, sedatives or sleeping pills _____ Y N DK

Sulfa Drugs _____ Y N DK

Codeine or other narcotics _____ Y N DK

Metals_____ Y N DK

Latex (rubber) _____ Y N DK

Iodine _____ Y N DK

Food _____ Y N DK

Other_____ Y N DK

Do you have an artificial (prosthetic) heart valve?	Y N DK
Any previous infective endocarditis?	Y N DK
Do you have damaged valves in transplanted heart?	Y N DK
Any Congenital Heart Disease (CHD)	
Unrepaired, cyanotic CHD?	Y N DK
Repaired (completely) in the last 6 months?	Y N DK
Repaired CHD with residual defects?	Y N DK

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

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Cardiovascular disease. ..... Y N DK
Angina ..... Y N DK
Arteriosclerosis .... Y N DK
Congestive heart failure ..... Y N DK
Damaged heart valves..... Y N DK
Heart attack ..... Y N DK
Heart murmur ..... Y N DK
Low blood pressure..... Y N DK
High blood pressure..... Y N DK
Other heart defects ……Y N DK
Mitral valve prolapse ..... Y N DK
Pacemaker ..... Y N DK
Rheumatic fever ..... Y N DK
Rheumatic heart disease……Y N DK
Abnormal bleeding ..... Y N DK
Anemia..... Y N DK
Blood transfusion ..... Y N DK
If yes, date:_____
Hemophilia ..... Y N DK
AIDS or HIV infection ..... Y N DK
Arthritis ..... Y N DK
Autoimmune disease ..... Y N DK
Rheumatoid arthritis ..... Y N DK
Systemic lupus erythematosus Y N DK
Asthma..... Y N DK
Bronchitis..... Y N DK
Emphysema ..... Y N DK
Sinus trouble ..... Y N DK
Tuberculosis ..... Y N DK
Cancer/Chemotherapy/
Radiation Treatment ..... Y N DK
Chest pain upon exertion ..... Y N DK
Chronic pain ..... Y N DK
Diabetes Type I or II ..... Y N DK
Eating disorder..... Y N DK
Malnutrition..... Y N DK
Gastrointestinal disease..... Y N DK

G.E. Reflux/heartburn ..... Y N DK
Ulcers ..... Y N DK
Thyroid problems ..... Y N DK
Stroke..... Y N DK
Glaucoma..... Y N DK
Hepatitis, jaundice or
liver disease ..... Y N DK
Epilepsy ..... Y N DK
Fainting spells or seizures..... Y N DK
Neurological disorders..... Y N DK
If yes,specify:_____
Sleep disorder ..... Y N DK
Mental health disorders ..... Y N DK
Specify:_____
Recurrent Infections ..... Y N DK
Type of infection:_____
Kidney problems..... Y N DK
Night sweats..... Y N DK
Osteoporosis..... Y N DK
Persistent swollen glands ….. Y N DK
Severe headaches/
migraines ..... Y N DK
Severe or rapid weight loss ..... Y N DK
Sexually transmitted disease .. Y N DK
Excessive urination..... Y N DK

Do you have any disease, condition, or problem not listed above?.....Y N DK

Please Explain Any and All That You Answered Yes to:

_____
_____
_____
_____
_____
_____

Please List ALL Medications (including those that are supplements or Over the Counter):_____
_____
_____
_____

I certify that I have read and understand that the above information given on this form is accurate. I understand the importance of an honest health history and that my dentist and her staff will rely on this information for treating me. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of error or omissions the I may have made in the completion of this form.

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_____ _____

Signature of Patient/Legal Guardian Date