BURKE DENTAL, PLLC

ADULT REGISTRATION FORM

LAST NAME	FIRST NAME	MI	SSN
DOB	GENDER: M / F	MARITAL STATUS: S / M / D / W	NAME OF SPOUSE
ADDRESS			
CITY	STATE	ZIP	REFERRED TO OFFICE BY
HOME PHONE	WORK PHONE	CELL PHONE	
YOUR E-MAIL ADDRESS	EMPLOYER		
SPOUSE'S EMPLOYER	SPOUSE'S WORK PHONE	SPOUSE'S CELL PHONE	
PHYSICIAN	PHONE	CITY/STATE	
EMERGENCY CONTACT	EMERGENCY PHONE	PHARMACY PHONE	

MEDICAL HISTORY

Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION
		ABNORMAL BLEEDING			GLAUCOMA			STROKE
		ALCOHOL ABUSE			HIV+ AIDS			THYROID PROBLEMS
		ALLERGIES			HAY FEVER			TUBERCULOSIS
		ANEMIA			HEART ATTACK			ULCERS
		ANGINA PECTORIS			HEART MURMUR			YELLOW JAUNDICE
		ARTHRITIS			HEART SURGERY			**ALLERGIES**
		ARTIFICIAL BONES			HEMOPHILIA			ASPIRIN
		ARTIFICIAL HEART VALVE			HEPATITIS A			CODEINE
		ASTHMA			HEPATITIS B			DENTAL ANESTHETICS
		BLOOD TRANSFUSION			HEPATITIS C			ERYTHROMYCIN
		CANCER-CHEMOTHERAPY			HIGH BLOOD PRESSURE			JEWELRY
		COLITIS			HPV			LATEX
		CONGENITAL HEART DEFECT			KIDNEY PROBLEMS			METALS
		COSMETIC SURGERY			LIVER DISEASE			PENICILLIN
		DIABETES			LOW BLOOD PRESSURE			TETRACYCLINE
		DIFFICULTY BREATHING			MITRAL VALVE PROLAPSE	OTHER ALLERGIES		
		DRUG ABUSE			PREMED			
		EMPHYSEMA			PACE MAKER	**Y**	**N**	
		EPILEPSY			PAIN IN JAW JOINTS			SMOKE OR CHEW TABACCO?
		FAINTING SPELLS			PSYCHIATRIC PROBLEMS			**FEMALES ONLY:**
		FEVER BLISTERS			RHEUMATIC FEVER			PREGNANT OR NURSING
		FREQUENT HEADACHES			SEIZURES			TAKING BIRTH CONTROL PILLS
					SINUS PROBLEMS			

PLEASE LIST ALL MEDICATIONS THAT YOU ARE PRESENTLY TAKING:

HAS ANYONE EVER TOLD YOU THAT YOU SNORE? Y / N

IS THERE ANY DISEASE, CONDITION, OR PROBLEM THAT YOU THINK THIS OFFICE SHOULD KNOW ABOUT THAT IS NOT COVERED ABOVE?

HAVE YOU EVER TAKEN ANY BISPHOSPHONATES MEDICATIONS (such as Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, Zometa, or Reclast)? Y / N

HAVE YOU EVER HAD ANY BAD EXPERIENCES AT THE DENTAL OFFICE?

IS THERE ANYTHING THAT YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE?

OFFICE POLICIES AND CONSENT FOR TREATMENT

BEFORE TREATMENT CAN BE RENDERED, ADEQUATE RADIOGRAPHS OF THE TEETH AND MOUTH MUST BE TAKEN.

WE USE LOCAL ANESTHETIC AND OTHER METHODS OF PAIN CONTROL TO MAKE OUR PATIENTS MORE COMFORTABLE WHILE RECEIVING DENTAL TREATMENT.

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, CONSENT TO THE PERFORMING OF DENTAL OR ORAL SURGICAL PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE, AND I WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THOSE PROCEDURES.

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, WAS GIVEN A COPY OF BURKE DENTAL, PLLC NOTICE OF PRIVACY PRACTICES.

INSURANCE INFORMATION

Sponsor's Name	Sponsor's DOB	Sponsor's SSN
PRINT YOUR NAME		
SIGNATURE		DATE

For Office Use Only: Entered by______________Checked by______________Scanned By______________