HoHoKus perio

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PATIENT REGISTRATION AND HEALTH HISTORY

Patient Name _____ ___ _____ Email _____
FIRST MI LAST

Address _____
STREET CITY STATE ZIP

Cell Phone _____ Home Phone _____ Business Phone _____

☐ Male ☐ Female ☐ Single ☐ Married Name of Spouse _____

Date of Birth ____/____/____ Social Security Number ____/____/____

Emergency Contact Name _____ Phone _____

General Dentist Name _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Physician Name _____ City _____

Have you had a serious illness, operation, or hospitalization in the last five years? ☐ Yes ☐ No
If so, please explain below:

Have you ever had or been treated for: (check all that apply)

☐ Anemia	☐ Cancer	☐ Heart Valve	☐ Rheumatic Fever
☐ Asthma	☐ Diabetes	☐ Hepatitis	☐ Sinus Condition
☐ Bleeding/Clotting Disorder	☐ Dry Mouth	☐ High Cholesterol	☐ Stroke
☐ Blood Pressure: High	☐ Heart Disease	☐ Immunocompromised Disease	☐ Tuberculosis
☐ Blood Pressure: Low	☐ Heart Murmur	☐ Mental Illness	

☐ Other: _____

List all current medications and dosage:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you had a joint replacement, infective endocarditis, or an artificial heart valve? ☐ Yes ☐ No

Do you take antibiotics prior to dental appointments? ☐ Yes ☐ No
If so, which antibiotic and what is your dose?

Recent Dental Cleaning _____

Tobacco Use:

Have you ever used tobacco? ☐ Yes ☐ No
Do you currently use tobacco? ☐ Yes ☐ No
If yes, how much do you use? _____
If no, how long has it been since you stopped? _____

Have you ever had an allergic reaction to any of the following? (check all that apply)

☐ Penicillin or other Antibiotics ☐ Latex ☐ Food ☐ Aspirin ☐ Codeine
☐ Local Anesthetics ☐ Iodine ☐ Sulfa Drugs ☐ Other: _____

Women: Pregnant/Nursing ☐ Yes ☐ No Birth Control Pills ☐ Yes ☐ No

Chief Dental Compliant:

Note: Please discuss any and all relevant patient health issues with Dr. Voskian.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other staff member, responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form.

_____ _____
Signature (Patient or Legal Representative for Patient) Date

_____
Michael J. Voskian, DMD

FOR COMPLETION BY DENTIST

Date _____ Change in Health Information

Date _____ Change in Health Information

Date _____ Change in Health Information

Date _____ Change in Health Information

Date _____ Change in Health Information