



MICHAEL J. VOSKIAN, DMD

NJ SPEC. LIC. #3817

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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)

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Heart Valve               | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> Sinus Condition |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Dry Mouth     | <input type="checkbox"/> High Cholesterol          | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Blood Pressure: High       | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Immunocompromised Disease | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Blood Pressure: Low        | <input type="checkbox"/> Heart Murmur  | <input type="checkbox"/> Mental Illness            |  |
| <input type="checkbox"/> 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)

<input type="checkbox"/> Penicillin or other Antibiotics	<input type="checkbox"/> Latex	<input type="checkbox"/> Food	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine
<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Iodine	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Other: _____	

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

Chief Dental Complaint:

**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*