DAVID S.
dennisdds
Where creating radiant, confident smiles is a lasting tradition

11354 Mountain View Avenue, Suite B | Loma Linda, CA 92354 | (909) 796-5199

PATIENT REGISTRATION INFORMATION			
Name, (Last, First, Middle) ☐ Mr ☐ Ms ☐ Dr			Social Security Number | | |-| | |-| | | |
Parent/Guardian		Home Phone: _____ Cell Phone: Work Phone:	EMAIL
Address		City State	Zip
Date of Birth	Sex ☐ M ☐ F	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Driver's License #
Place of Employment Occupation:		Work Address	
In emergency, contact:		Relationship	Phone
REASON FOR VISIT		Name of Primary Care Doctor: Phone:	
HEALTH INSURANCE INFORMATION			
PRIMARY INSURANCE CARRIER'S NAME			
Insurance Carrier's Address		City State	Zip
Name of Insured		Relationship ☐ Self ☐ Spouse ☐ Child	Insured's Phone
ID# DOB: Social Security #:		Group #	
SECONDARY INSURANCE			ID #

PHOTO RELEASE	
I hereby authorize Dr. David Dennis to publish the photographs taken of my or my minor child's dental work on his website. I acknowledge that since my participation is voluntary, I will receive no financial compensation. I release Dr. David Dennis, his contractors and his employees from liability for any claims by me in connection with my participation.	☐ Yes, I authorize ☐ No, I do not authorize Initials _____

_____ _____

Patient Signature (if patient is a minor, Parent/Guardian Signature) Date

_____ _____

Witness Date

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Health History

Please circle "yes" if you have ever had the following and circle "no" if it does not apply.

HEART/BLOOD VESSELS

Rheumatic fever	Yes	No
Rheumatic heart disease	Yes	No
Heart valve damage	Yes	No
Heart murmur	Yes	No
Congenital heart defect	Yes	No
Artificial heart valve	Yes	No
Prolapsed heart valve	Yes	No
High blood pressure	Yes	No
Heart attack (Date _____)	Yes	No
TIA/Stroke (Date_____ _____)	Yes	No
Heart Surgery (Date _____)	Yes	No
Vascular Surgery (Date_____)	Yes	No
Pacemaker	Yes	No
Coronary heart failure	Yes	No
Congestive heart failure	Yes	No
Angina pectoris/chest pain	Yes	No
Irregular/rapid heart beats	Yes	No
Other heart or vessel disorder .	Yes	No

BLOOD

Blood clots or thrombosis	Yes	No
Anemia	Yes	No
Sickle cell disease/trait	Yes	No
Hemophilia	Yes	No
Transfusion (Date_____)	Yes	No
Bruise easily for no apparent reason	Yes	No
Other blood disorder	Yes	No

NERVOUS SYSTEM

Epilepsy	Yes	No
Seizure disorder	Yes	No
Multiple sclerosis	Yes	No
Trigeminal neuralgia	Yes	No
Chronic pain	Yes	No
Anxiety/depression	Yes	No
Alzheimer's disease/dementia .	Yes	No
Psychiatric treatment	Yes	No
Psychological counseling	Yes	No
Persistent dizziness/fainting spells	Yes	No
Other nervous system/mental disorder	Yes	No

HEAD AND NECK

Glaucoma	Yes	No
Chronic sinusitis	Yes	No
Injury to head, neck, jaw or teeth	Yes	No
Headaches	Yes	No
Unexplained visual change	Yes	No
Frequent or severe nosebleeds.	Yes	No
Persistent sore throat or hoarseness	Yes	No
Recurrent neckache or neck pain	Yes	No
Recent difficulty swallowing	Yes	No
Other head or neck disorder	Yes	No

ENDOCRINE

Diabetes	Yes	No
Low thyroid	Yes	No
Other thyroid condition	Yes	No
Cushings syndrome	Yes	No
Parathyroid condition	Yes	No
Other endocrine condition	Yes	No

MUSCULOSKELETAL/CONNECTIVE TISSUE

Sjögren's syndrome	Yes	No
Arthritis	Yes	No
Artificial joint (Date_____)	Yes	No
Fibromyalgia/rheumatism	Yes	No
Chronic back pain	Yes	No
Other muscle or bone disorder.	Yes	No

RESPIRATORY

Tuberculosis (TB)	Yes	No
Asthma	Yes	No
Chronic bronchitis	Yes	No
Emphysema	Yes	No
Persistent cough	Yes	No
Cough up bloody sputum	Yes	No
Shortness of breath	Yes	No
Other respiratory disorder	Yes	No

URINARY TRACT

Kidney disease	Yes	No
Renal dialysis	Yes	No
Venereal disease	Yes	No
Sexually transmitted disease	Yes	No
Other urinary disorder	Yes	No

DIGESTIVE SYSTEM

Hepatitis	Yes	No
Cirrhosis of the liver/liver disease	Yes	No
Ulcers	Yes	No
Jaundice	Yes	No
Frequent heartburn or reflux	Yes	No
Frequent nausea/vomiting	Yes	No
Other digestive disorder	Yes	No

CANCER HISTORY

Cancer	Yes	No
If yes, what type _____		
Leukemia	Yes	No
Benign tumors/growths	Yes	No
Type of treatment:		
Surgery	Yes	No
Radiation therapy	Yes	No
Chemotherapy	Yes	No
Hormone therapy	Yes	No

ALLERGY HISTORY

Are you allergic to or have you ever had a bad reaction to any of the following?

Dental anesthetics	Yes	No
Penicillin	Yes	No
Sulfa drugs	Yes	No
Other antibiotics	Yes	No
Aspirin	Yes	No
Latex products	Yes	No
Metals, including jewelry	Yes	No
Other allergy	Yes	No

FAMILY HISTORY

Has anyone in your family (grandparent, parent, sibling, child) ever had:

Diabetes	Yes	No
Heart disease	Yes	No
Depression or anxiety	Yes	No
Tuberculosis	Yes	No
Any disorder that "runs in" your family	Yes	No

PLEASE CONTINUE ON OTHER SIDE

HEALTH HISTORY QUESTIONNAIRE (continued)

Please circle "yes" if you have ever had the following. If you are not sure, do not answer the question.

MISCELLANEOUS

Lupus erythematosus..... Yes No
Organ transplant..... Yes No
If yes, which organ? _____
Suppressed immune system..... Yes No
Persistent fever ..... Yes No
Taken steroid/prednisone ..... Yes No
Tested positive for HIV ..... Yes No
Been diagnosed with AIDS ..... Yes No
Taken prescription diet pills ..... Yes No
If yes, please check type:
☐ Pondimin ☐ Phen-fen
☐ Redux ☐ Other _____

MISCELLANEOUS (CONTINUED)

Used tobacco products..... Yes No
If yes, what type? _____
How much? _____ How long? _____
Still using tobacco? ..... Yes No
Would you like to quit? ..... Yes No
Quit on? (Date _____)
Drink alcoholic beverages ..... Yes No
If yes, how much? _____
Used methamphetamine, amphetamines or "speed" ..... Yes No
Used intravenous drugs ..... Yes No
Used cocaine or "crack" ..... Yes No

MISCELLANEOUS (CONTINUED)

Used any other recreational drug Yes No
Are you a recovering alcoholic or addict? ..... Yes No

WOMEN ONLY

Are you pregnant or is there a possibility that you may be pregnant? ..... Yes No
If yes, due date _____
Are you breast feeding? ..... Yes No
Are you in or have you passed through menopause (change of life)?.. Yes No

Do you have any other condition that you think we should know about? ☐ Yes ☐ No

_____

_____

Please circle all the medications you are currently taking:

Heart	Blood thinners	Hormones	Antibiotics	Tranquilizers
Nitroglycerin	Blood pressure	Insulin/diabetic drugs	Antihistamine	Antidepressants
Digitalis	Oral contraceptive	Thyroid	Cyclosporine A	Pain
Aspirin (_____ tabs/day)	Steroids/Cortisone	Nifedipine		

List medication names and dosages (include over-the-counter, herbal and nutritional supplements):

_____ _____

_____ _____

Have you had any serious Illness or Operation? Yes No
If so, what was the problem? _____

_____

I have answered all of the above Health History questions to the best of my knowledge

_____ _____
Signature of patient, parent or guardian in minor Date

The undersigned hereby authorizes Doctor or his agent to take x-rays, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy. I also understand the use of anesthetic agents embodies a certain risk. I understand that I am financially responsible for dental treatment personally and that insurance benefits will be assigned to the Doctor. I have fully completed the above health questionnaire and advised you of all medical problems of which I am aware.

_____ _____
Signature of patient, parent or guardian in minor Date

HEALTH UPDATES *[Required at least every six (6) months; more often as indicated]*

Date	Note changes below	Patient Signature