



STEVEN A. STEC DDS, PC
Cosmetic and Family Dentistry

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PATIENT REGISTRATION

NAME _____

SPOUSE/PARENT'S NAME IF CHILD _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ EMAIL _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

BIRTHDATE _____ AGE _____ GENDER M OR F MARITAL STATUS SINGLE MARRIED WIDOWED DIVORCED SEPARATED

SOCIAL SECURITY NUMBER _____ WHO MAY WE THANK FOR REFERRING YOU? _____

EMERGENCY CONTACT _____ EMERGENCY CONTACT PHONE # _____ RELATIONSHIP TO PATIENT _____

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE? Y OR N NAMES: _____ RELATIONSHIP TO PATIENT _____

WHERE & WHEN IS THE BEST TIME TO REACH YOU _____

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME _____

RELATIONSHIP TO PATIENT _____ SSN# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____

EMAIL _____

DENTAL INSURANCE

INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____

INSURANCE COMPANY PHONE # _____

POLICY HOLDER _____

DATE OF BIRTH _____ RELATIONSHIP _____

GROUP # _____

EMPLOYEE SS# OR ID# _____

ABOUT YOU

EMPLOYER _____ YRS EMPLOYED _____

OCCUPATION _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

BUSINESS PHONE _____

OTHER _____

ABOUT YOUR SPOUSE

EMPLOYER _____

OCCUPATION _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

BUSINESS PHONE _____

OTHER _____

CONSENT

CONSENT FOR TREATMENT FOR _____ PLEASE PRINT PATIENT'S NAME

To the best of my knowledge the information provided is accurate and complete. Any changes in health status or medications will be reported to the Doctor at the next visit following the change. In addition, I authorize the Doctor or his representative to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis and to develop proper treatment recommendations. I understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless other arrangements have been made in advance. Responsibility for paying any co-pay and/or deductibles that my insurance does not cover will be mine.

SIGNATURE _____ DATE _____

PATIENT PARENT GUARDIAN

(TURN OVER TO COMPLETE)

MEDICAL HISTORY

GENERAL HEALTH EXCELLENT GOOD FAIR POOR

NAME OF PHYSICIAN _____ PHONE No. _____

HAVE YOU BEEN UNDER MEDICAL CARE IN THE LAST 2 YEARS? YES NO IF YES, EXPLAIN _____

LAST COMPLETE PHYSICAL _____ LAST BLOOD PRESSURE CHECK _____ BLOOD PRESSURE _____

DO YOU NEED TO BE PRE-MEDICATED (TAKE ANTIBIOTICS) BEFORE DENTAL TREATMENT? _____

LIST ALL MEDICATIONS YOU TAKE _____

HAVE YOU BEEN TREATED FOR:

- | | | | |
|--|--|--------------------------------|--|
| ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) | <input type="checkbox"/> YES <input type="checkbox"/> NO | HEPATITIS OR JAUNDICE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ANEMIA | <input type="checkbox"/> YES <input type="checkbox"/> NO | HEART DISEASE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ARTHRITIS | <input type="checkbox"/> YES <input type="checkbox"/> NO | ABNORMAL BLOOD PRESSURE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ASTHMA | <input type="checkbox"/> YES <input type="checkbox"/> NO | CONGENITAL HEART DEFECTS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CANCER | <input type="checkbox"/> YES <input type="checkbox"/> NO | MURMUR | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| WHAT TYPE _____ | | RHEUMATIC FEVER | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| RADIATION TREATMENT | <input type="checkbox"/> YES <input type="checkbox"/> NO | STROKE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CHRONIC COUGH | <input type="checkbox"/> YES <input type="checkbox"/> NO | JOINT REPLACEMENT | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| DIABETES | <input type="checkbox"/> YES <input type="checkbox"/> NO | MULTIPLE SCLEROSIS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| DRY MOUTH (XEROSTOMIA) | <input type="checkbox"/> YES <input type="checkbox"/> NO | OSTEOPOROSIS DRUGS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| EPILEPSY | <input type="checkbox"/> YES <input type="checkbox"/> NO | SINUS TROUBLES/ALLERGIES | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| GLAUCOMA | <input type="checkbox"/> YES <input type="checkbox"/> NO | TUBERCULOSIS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HIGH BLOOD PRESSURE | <input type="checkbox"/> YES <input type="checkbox"/> NO | ULCERS | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| LOW BLOOD PRESSURE | <input type="checkbox"/> YES <input type="checkbox"/> NO | VD (SYPHILIS, GONORRHEA) | <input type="checkbox"/> YES <input type="checkbox"/> NO |

ARE YOU ALLERGIC TO: PENICILLIN CODEINE LOCAL ANESTHETICS LATEX CECLOR SULFA ERYTHROMYCIN OTHER _____

ARE YOU SUBJECT TO PROLONGED BLEEDING YES NO | FAINTING SPELLS OR DIZZY SPELLS | YES NO |

DO YOU HAVE ANY CONDITION NOT LISTED YES NO | IF YES, EXPLAIN _____ | |

(WOMEN) ARE YOU PREGNANT YES NO HOW LONG? _____ TAKING BIRTH CONTROL YES NO NURSING YES NO

DENTAL HISTORY

DATE OF LAST DENTAL VISIT _____

DID YOU HAVE X-RAYS TAKEN YES NO DATE OF LAST DENTAL CLEANING _____

DO YOU WEAR FULL OR PARTIAL DENTURES YES NO IF YES, HOW OLD ARE THEY _____

HAVE YOU HAD ALL OF YOUR TEETH X-RAYED IN THE PAST 3 YEARS YES NO |

ARE YOU DISSATISFIED WITH THE APPEARANCE OF YOUR TEETH OR SMILE YES NO |

WOULD YOU CHANGE YOUR SMILE IF YOU COULD YES NO |

DO YOU SNORE OR HAVE SLEEP APNEA YES NO |

HAVE YOU HAD ORTHODONTIC TREATMENT YES NO |

DO YOU CLENCH OR GRIND YOUR TEETH DURING THE NIGHT YES NO |

HAVE YOU EVER HAD A PAIN IN YOUR JAW JOINT OR YOUR FACE OR AROUND YOUR EAR YES NO |

DO YOU HAVE FREQUENT HEADACHES YES NO |

DOES YOUR JAW JOINT CLICK OR POP YES NO |

DO YOU HAVE DIFFICULTY OPENING YOUR MOUTH WIDELY YES NO |

DO YOU HAVE AN UNPLEASANT ODOR OR TASTE IN YOUR MOUTH YES NO |

DO YOUR GUMS BLEED WHEN BRUSHING YES NO |

HAVE YOU EVER BEEN DIAGNOSED WITH GUM DISEASE YES NO |

IS YOUR MOUTH OR TEETH SENSITIVE TO PRESSURE YES NO | COLD YES NO | HOT YES NO |

DOES FOOD CATCH BETWEEN YOUR TEETH YES NO |

DO YOU HAVE DIFFICULTY GETTING NUMB FOR DENTAL TREATMENT YES NO |

PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT FOR THE DOCTOR TO KNOW (ANY SPECIAL CONCERNS) _____

MEDICAL HISTORY UPDATE

1. DATE _____ COMMENTS _____ SIGNATURE _____

2. DATE _____ COMMENTS _____ SIGNATURE _____

3. DATE _____ COMMENTS _____ SIGNATURE _____