



Dr. H. Derick Phan D.D.S., C.A.G.S

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**PATIENT REGISTRATION
HISTORY-ADULT**

Mr. Mrs. _____ Date ____/____/____

Ms. Dr. _____ Male Female D.O.B. ____/____/____

First Middle Last

Home Address _____
Street City State Zip

Home Phone _____ Cell _____ **E-Mail** _____

Business Phone _____ Insurance Company _____ Employer _____

Spouse's Name _____ D.O.B. ____/____/____ Insurance Company _____

Patient's Social Security No. ____-____-____ Spouse's Social Security No. ____-____-____

Referred By? _____

MEDICATIONS CURRENTLY TAKING:

PLEASE CHECK YES OR NO TO THE FOLLOWING:

YES NO

- Has patient had a physical exam in the past year?
- Is patient presently under a physician's care?
- Has Patient ever been hospitalized?
- Is patient taking any pills, medications or drugs?
- Has patient ever had major surgery?

YES NO

- Has patient had any reactions to any medications?
- Has patient had his/her tonsils and/or adenoids removed?
- Does patient experience fainting or dizzy spells?
- Does patient have too high or too low blood pressure?

HAS PATIENT BEEN DIAGNOSES OR TREATED FOR:

- | Yes | No | Yes | No |
|--------------------------|--------------------------|--------------------------|--------------------------|
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PLEASE CHECK IF PATIENT IS ALLERGIC TO THE FOLLOWING:

- Aspirin Codeine Penicillin Sulfa Latex Metals
- Other _____

Dr. Notes:

MEDICAL ALERT
Yes No

Are there any other medical problems I should be aware of? _____

DENTAL HISTORY

DENTIST NAME _____ **PHONE** _____ **DATE OF LAST CLEANING** ____/____/____

Yes No

- Has patient ever had orthodontic consultation or treatment?
- Has patient been informed of any missing teeth?
- Have any permanent teeth been removed by extraction?
- Has a family member had orthodontic treatment?
Who? _____
- Does patient breathe predominately through his/her mouth?
- Does patient have any speech problems?
- Does patient now suck his/her thumb or finger?

Yes No

- Does patient grind or clench his/her teeth?
- Does patient have pain or clicking of the jaw?
- Has patient ever had any teeth injured by due to an accident?
- Has patient ever had pains in the face?
- Has patient ever had severe jaw or head injury?
- Does patient want his/her teeth straighten?
- Does patient's gums bleed when brushing or flossing?

Are there any other dental/orthodontic problems I should be aware of? _____

Patient's signature _____ Date ____/____/____