PATIENT REGISTRATION FORM

BUR-OAK DENTAL
ZACH SIEFRING, D.M.D.
440 BUR-OAK DRIVE
GREENVILLE, OHIO 45331
PH: 937-548-5496

Preferred Name: O Mr. O Mrs. O Miss O Dr.		
Name: Last	First	Middle
Home Phone #:	Cell Phone #:	
Address:		
Date of Birth:	SS#:	Sex: O M O F
Email:		
Emergency Contact:	Relationship:	Phone:
Employer:	Employer Phone:	
Employment Status: O Full Time O Part Time O Retired O Unemployed School Status: O Full Time O Part Time		
Marital Status: O Married O Divorced O Separated O Widowed O Single		
Preferred Pharmacy:	Location (city):	

DENTAL INSURANCE FORM

Name of Insured:	Relationship to Patient: O Self O Spouse O Parent O Other
Insured Social Security #:	Insured Birth Date:
Insured Employer:	
Insurance Company:	Insurance Company Phone #:
Address of Insurance Company:	Insurance ID #:
	Group ID#:

DENTAL HISTORY FORM

Please mark your response:

	Y	N		Y	N
Do your gums bleed when you brush/floss?	O	O	Do you brux or grind your teeth?	O	O
Have you had previous periodontal (gum) treatment?	O	O	Do you have clicking/popping/discomfort?	O	O
Do you suffer from dry mouth?	O	O	Do you suffer from frequent headaches/earaches?	O	O
Do you frequently get sores or ulcers in your mouth?	O	O	Do you wear dentures or partials?	O	O
Have you had previous orthodontic (braces) treatment?	O	O			

Date of last dental exam?
Date of last dental x-rays?
Are you currently experiencing any dental pain?
How do you feel about your smile?
Reason for appointment?

I certify that that I have read and understand the above and that the information given on this form for self or given by legal guardian is accurate:	
Signature:	Date:

Medical History Form

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Are you under a physician's care now? ☐ Yes ☐ No If yes ______________________________

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes ______________________________

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes ______________________________

Do you use tobacco? ☐ Yes ☐ No If yes ______________________________

Do you use controlled substances? ☐ Yes ☐ No If yes ______________________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes ______________________________

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No ______________________________

Woman Are you…

☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following?

☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Local Anesthetic ☐ Metal ☐ Penicillin
☐ Latex ☐ Sulfa Drug ☐ Other If yes ______________________________

Do you have, or have you had, any of the following?

☐ AIDS/HN Positive	☐ Chron's Disease	☐ Hemophilia	☐ Radiation treatment
☐ Alcohol Abuse	☐ Cold Sores/Fever Blisters	☐ Hepatitis A	☐ Renal Dialysis
☐ Alzheimer's Disease	☐ Congenital Heart Disease	☐ Hepatitis B/C	☐ Rheumatism
☐ A Radiation Treatment	☐ COPD	☐ High Blood Pressure	☐ Shingles
☐ Anaphylaxis	☐ Cortisone/Steroids	☐ High Cholesterol	☐ Sinus Trouble
☐ Anemia	☐ Diabetes	☐ Irregular Heartbeat	☐ Stomachic Intestinal Disease
☐ Angina	☐ Drug Addiction	☐ Kidney Problems	☐ Stroke
☐ Arthritis/Gout	☐ Emphysema	☐ Leukemia Stroke	☐ Thyroid Disease
☐ Artificial Heart Valve	☐ Epilepsy/Seizures	☐ Liver Disease	☐ Tonsilitis
☐ Artificial Joint	☐ Excessive Bleeding	☐ Low Blood Pressure	☐ Tuberculosis
☐ Asthma	☐ Glaucoma	☐ Lung Disease	☐ Ulcerative Colitis
☐ Blood Disease	☐ Heart Attack/Failure	☐ Mitral Valve Prolapse	
☐ Blood Transfusion	☐ Heart Murmur	☐ Osteoporosis	
☐ Cancer	☐ Heart Pacemaker	☐ Parathyroid Disease	
☐ Chemotherapy	☐ Heart Trouble/Disease	☐ Psychiatric Care	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No
If yes ______________________________