

# Fulton Dental PC

## Dental Registration and History

1371 Rockaway Parkway  
Brooklyn, NY 11236  
(718) 257-1717

### 1. PATIENT INFORMATION

Patient Name \_\_\_\_\_  
Last Name First Name Middle Initial

Date \_\_\_\_\_ Birthday \_\_\_\_\_

SS# or Insurance ID# \_\_\_\_\_ Sex  M  F

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Tel \_\_\_\_\_ Work Tel \_\_\_\_\_

Mobile # \_\_\_\_\_ Occupation \_\_\_\_\_

Email \_\_\_\_\_ Marital Status \_\_\_\_\_

Referral Source \_\_\_\_\_

Notes \_\_\_\_\_

### 2. EMPLOYER / SCHOOL

Employer/ School Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Notes \_\_\_\_\_

### 3. EMERGENCY CONTACT

Emergency Contact Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

### 4. INSURANCE INFORMATION

Responsible Party Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Group # \_\_\_\_\_ SS# \_\_\_\_\_

Birthday \_\_\_\_\_ Other Coverage  Yes  No

#### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with:

\_\_\_\_\_

and assigned directly to Dr. \_\_\_\_\_ all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information in the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### 5. DENTAL HISTORY

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ Tel \_\_\_\_\_ Last X-Ray Date \_\_\_\_\_

Last Cleaning \_\_\_\_\_ Last Dental Visit \_\_\_\_\_

Do you feel pain  Yes  No if yes please describe \_\_\_\_\_

Do you feel numbness, swelling, or any other sensitivity?  Yes  No if yes please explain \_\_\_\_\_

Additional comments about your past dental history \_\_\_\_\_

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### 6. HEALTH HISTORY

Physician Name \_\_\_\_\_ Physician Tel \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentennlne), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type ___	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Women: Are you pregnant?  Yes  No If yes due date: \_\_\_\_\_ Are you nursing?  Yes  No

### 7. MEDICATION & ALLERGIES

Please list all the medication you are currently taking \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any known allergies \_\_\_\_\_

\_\_\_\_\_

Are you allergic to any of the following?  Yes  No

If yes please circle: Aspirin, Barbiturates (Sleeping pills), Codeine, Iodine,

Latex, Local Anesthetic, Penicillin

Any other allergies?  Yes  No

### 8. UPDATES (for future visits)

Date \_\_\_\_\_

Changes to medical history \_\_\_\_\_

\_\_\_\_\_

Patient Signature \_\_\_\_\_

Doctor Signature \_\_\_\_\_

Date \_\_\_\_\_

Changes to medical history \_\_\_\_\_

\_\_\_\_\_

Patient Signature \_\_\_\_\_

Doctor Signature \_\_\_\_\_