Antigua

Dr. Rebecca A. Faunce D.M.D.

Adult Registration and History

Please fill out completely prior to your scheduled appointment.

Patient's Name (Mr.,Ms.,Mrs.,Miss)_____

Birth Date_____ SS#_____ Male/Female **Email** _____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work_____ Cell_____

Employer_____ Occupation_____ Email_____

Spouse's Name/Incase of Emergency Call_____

Whom may we thank for referring you _____

How did you hear about our office.(Phone Book,Internet,facebook,etc)_____

Contact In case of emergency:

Name:_____ **Relationship:**_____ **Phone Number:**_____

Dental Insurance

Primary Subscriber's Name_____ DOB_____

SS#_____ Insurance Company_____

Group#_____ ID#_____ Ins. Phone_____

Secondary Subscriber's Name_____ DOB_____

SS#_____ Insurance Company_____

Group#_____ ID#_____ Ins. Phone_____

Dental History

Dentist Name_____ Phone_____

Date of Last Dental Visit_____ For What Service_____

YES NO

- ☐ ☐ Are you having any discomfort. If yes explain_____
- ☐ ☐ Any serious trouble associated with treatment. If yes explain_____
- ☐ ☐ Any injuries to: Mouth-Teeth-Head. If yes explain_____
- ☐ ☐ Does dental treatment make you nervous. If yes explain_____
- ☐ ☐ Have you ever been treated for periodontal disease. (Gum Disease,Pyorrhea,Trench Mouth) If yes explain_
- ☐ ☐ Any lost teeth. If yes explain_____
- ☐ ☐ Have missing teeth been replaced. If yes explain_____

How often do you brush_____ floss_____ Toothbrush is Soft_____, Medium____, Hard_____.

- ☐ ☐ Orthodontic appliances worn now or ever been worn _____
- ☐ ☐ Any family member that is in or has had orthodontic treatment with our office. If yes which office and name of family member

_____

Do you have or have you ever had any of the Following:

Mouth

YES NO

- ☐ ☐ Bleeding, Sore Gums
- ☐ ☐ Unpleasant Taste/Breath
- ☐ ☐ Burning Tongue/Lips
- ☐ ☐ Frequent Blisters, Lip/Mouth
- ☐ ☐ Swelling/Lumps in Mouth
- ☐ ☐ Biting Cheeks/Lips
- ☐ ☐ Clicking/Popping Jaw
- ☐ ☐ Difficulty Opening or Closing Jaw

Teeth

YES NO

- ☐ ☐ Loose Teeth
- ☐ ☐ Sensitive to Hot
- ☐ ☐ Sensitive to Cold
- ☐ ☐ Sensitive to Sweets
- ☐ ☐ Sensitive to Biting
- ☐ ☐ Clenching/Grinding. if yes
- ☐ ☐ Food Impaction
- ☐ ☐ Shifting/Change in Bite

Health History

Physician's Name_____ Phone_____

Date of last physical examination_____ Results_____

YES NO

- ☐ ☐ Are you under care of a physician now_____

☐ ☐ Have you been hospitalized in the past 5 years. If yes explain_____

☐ ☐ Have you had surgery in the past 5 years. If yes explain _____

☐ ☐ Has there been any changes in your general health within the past year. If yes explain_____

☐ ☐ Allergies to **ANY** drugs. If yes explain_____

☐ ☐ Allergies to **ANY**: Food-Pollen-Animals-**Latex**-Other _____

☐ ☐ Do your ankles swell_____

☐ ☐ Are you ever short of breath after mild exercise_____

☐ ☐ Do you have pain in chest upon exertion_____

☐ ☐ Do you get short of breath when you lie down, or do you require extra pillows when you sleep_____

☐ ☐ Do you urinate(pass water) more than six times a day_____

☐ ☐ Are you thirsty much of the time_____

☐ ☐ Does your mouth frequently become dry_____

☐ ☐ Have you ever tested positive for the AIDS Virus._____

☐ ☐ Have you ever required a blood transfusion. If yes explain_____

☐ ☐ Have you ever had a persistent cough or coughed up blood. If yes explain_____

☐ ☐ Do you use any tobacco products. If yes explain how much per day_____

☐ ☐ Do you use any alcohol products. If yes explain how much per week_____

☐ ☐Do you use any caffeinated products. If yes explain how much per day_____

☐ ☐ Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation. If yes explain_____

☐ ☐ Are you experiencing stress or pressure in your work or at home_____

☐ ☐ May we request release of your medical records_____

WOMEN ONLY

☐ ☐ Are you pregnant _____☐ ☐ Are you taking birth control or hormone therapy_____

☐ ☐ Do you have PMS or problems associated with your menstrual period._____

Do you have or have you had any of the following diseases or problems:

YES	NO	YES	NO	YES	NO
☐	☐ Anemia	☐	☐ Arthritis	☐	☐ Arteriosclerosis
☐	☐ Asthma	☐	☐ Bladder	☐	☐ Blood Pressure (high/low)
☐	☐ Bruise Easily	☐	☐ Cerebral Palsy	☐	☐ Chicken Pox
☐	☐ Chronic Sinus	☐	☐ Cardiovascular Disease	☐	☐ Congenital Heart Disease
☐	☐ Convulsions	☐	☐ Coronary Insufficiency	☐	☐ Diabetes
☐	☐ Digestive System(Ulcers or Stomach)	☐	☐ Epilepsy	☐	☐ Fainting
☐	☐ Hearing	☐	☐ Heart Trouble	☐	☐ Heart Attack
☐	☐ Heart Murmur	☐	☐ Hepatitis	☐	☐ Immune System (AIDS,HIV,ARC)
☐	☐ Inflammatory Rheumatism	☐	☐ Jaundice	☐	☐ Kidney Trouble
☐	☐ Liver Disease	☐	☐ Malignancies	☐	☐ Mastoid
☐	☐ Measles	☐	☐ Mononucleosis	☐	☐ Mumps
☐	☐ Pacemaker	☐	☐ Rheumatic Fever	☐	☐ Rheumatic Heart Disease
☐	☐ Stroke	☐	☐ Sinus trouble	☐	☐ Seizures
☐	☐ Thyroid	☐	☐ Tuberculosis	☐	☐ Venereal Disease
☐	☐ Artificial or replacement valve	☐	☐ Artificial or replacement joints	☐	☐ wear contact lenses

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

_____

_____

Doctors Summary:

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient_____**Date**_____

Signature of Dentist_____**Date**_____

201 Health Park Blvd. Suite 216 St. Augustine Florida 32086 Phone (904) 829-8899