GARDENS FAMILY DENTISTRY

Today's Date_____

Patient Registration:

Last Name_____ First Name_____ MI_____ Date of Birth_____ Age_____
Sex: M or F Soc. Sec. #_____ Please Circle One: Single Married Separated Widow
Mailing Address_____ City_____ State_____ Zip_____
Email_____ Home or Cell Phone_____
Employer_____ Occupation_____
If patient is a minor: Mother's DOB:_____ Father's DOB:_____
Name of Parent/Guardian_____ Parent/Guardian SS#_____
Person Responsible for Account_____ Relationship_____
Emergency Contact_____ Relationship_____ Phone_____
If you are filling this form out on behalf of another person, what is your relationship to that person?
Name_____ Relationship_____
Reason for today's visit? _____
How did you hear about us? In-home Mailer Social Media Insurance Website/Internet Family/Friend/Coworker

Dental Insurance Information:

Insured's Name_____ Insured's DOB_____
Insured's Employer_____ Insurance Co_____
Group Number_____ Insurance Phone #_____

Dental History:

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
Where do you want your dental health to be?	1	2	3	4	5	6	7	8	9	10

What would you like to change about your smile? Please circle all that apply:

☐ Color/Whitening ☐ Chipped Teeth ☐ Crowding ☐ Missing Teeth
☐ Bite ☐ Spaces ☐ Smile Makeover ☐ Other (please specify)
_____

Please share the following dates:

Last cleaning_____ Last oral cancer screening_____ Last complete x-rays_____
What is the most important thing to you about your future smile and dental health? _____
_____
What is the most important thing to you about your dental visit today? _____
Why did you leave your previous dentist?_____
_____

Consent:

The undersigned hereby authorizes Dr. Al-Azzawi to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Al-Azzawi to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Al-Azzawi to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

_____ _____ _____ _____
Signature of Patient/Legal Guardian Print Name Date Dentist Signature

GARDENS FAMILY DENTISTRY

Patient Name _____

Dental History Cont. – Please circle any of the following conditions that apply to you.

Appearance	Function	Habits	Previous Comfort Options
Crooked teeth	Bad bite	Cheek/lip biting	Nitrous Oxide
Discolored teeth	Difficulty chewing	Chewing on ice/foreign objects	Oral Sedation
Flat teeth	Difficulty opening/closing	Nail biting	
Misshaped teeth	Grinding/Clenching	Thumb sucking	
Overbite	Headaches	Sleep Patterns	
Spaces	Jaw joint pain	Sleep Apnea	
Worn teeth	Mouth breathing	Snoring	
Pain/Discomfort	Periodontal (Gum) Health		
Broken teeth/fillings	Bad breath		
Dry Mouth	Loose/Shifting teeth		
Sensitivity (hot, cold, sweet)	Previous perio/gum disease		
Pressure	Swollen/Irritated		

Please list family history or any circled:

_____

_____

_____

Social

Tobacco-How much_____ How many years_____ Alcohol-How much _____ How many years_____

Drugs-How much _____ How many years_____

Diet And Habits

Do you drink: Soda_____ Tea_____ Coffee_____

If so, how often? _____

Do you eat snacks between meals?_____

If yes, how often? _____

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Patient Name _____

Medical History : – Please circle any of the following conditions that apply to you.

Cancer
Type_____
Chemotherapy:
Date of Most Recent
_____
Radiation:
Date of Most Recent
_____

Cardiovascular
Angina (chest pain)
Artificial heart valve(s)
Heart Conditions
Heart Surgery
High/Low blood pressure
Mitral Valve Prolapse
Pacemaker
Rheumatic Fever
Scarlet Fever
Stroke

Endocrinology
Diabetes:
Last HBA1C Date & Level
_____
Hepatitis A/B/C
Jaundice
Kidney Disease
Liver Disease
Thyroid Disease:
[Hypo/Hyper]

Gastrointestinal
Ulcers (stomach)
Gastrointestinal Disease

Hematologic/Lymphatic
[Date of last IMR and level
____/____]
Anemia
Blood Disorder
Bruise Easily
Excessive Bleeding

Musculoskeletal
Arthritis
Artificial Joints
Jaw Joint Pain
Rheumatoid Arthritis

Neurological
Anxiety
Depression
Dizziness
Drug/Alcohol Addiciton
Fainting
Seizures
Psychiatric Illness

Respiratory
Asthma
Emphysema
Sinus Problems
Sleep Apnea
Tuberculosis

Viral Infections
AIDS
HIV Positive
HPV

Womens
Nursing
Currently Pregnant [Months_____]

Medical Allergies
Antibiotics
(Penicillin/Amoxicillin/Clindamycin)
Opioids
(Percocet, Oxycodone, Tylenol 3)
Latex
Local Anesthetics [Type_____]
NSAIDs
Other Allergies _____

Additional Comments: _____

Medications – List all medications and reasons for taking. _____

Are you under the care of a physician? If yes, please explain_____

Physician Name_____Address_____Phone_____

Have you had a serious illness, operation, or hospitalization in the past 5 years? If yes, please explain_____

Do you take vitamins, natural, or herbal supplements? If yes, please explain_____

Are you currently/have you ever taking any medication for Osteopenia/Osteoporosis or Bone Disease? If yes, please explain

Have you ever had surgery? If yes, please list date and explain_____