REGISTRATION FORM **DATE** ____________________

Mr. Mrs. Ms. Miss Dr.

Patient Name____
First M. Initial Last Name you like to be called

Birthdate ____/____/____ Age_____ Male Female Single Married Divorced Widowed

Mailing Address ____________________________________ Cell Phone (_______)_________________________

City, State, Zip _____________________________________ Home Phone (_______)________________________

Soc. Sec. # _______________________________________ E-mail ______________________________________

Employer ____ Occupation __________________________________

Work Phone (_______)______________________________ Is it O.K. to call you at work? Yes No

Spouse's Name ____________________________________ Occupation __________________________________

Employer ____ Work Phone (_______)_________________________

Whom may we thank for referring you? ____

In case of emergency, a local relative or friend to be notified (not living at same address).

Name ____ Relationship to Patient __________________________

Address ____ Phone (_______)_____________________________

DENTAL INSURANCE INFORMATION

Primary Insurance Co. _______________________________ Patient's Relationship to Subscriber:
Self Spouse Dependent

Mailing Address ____________________________________ Insurance Co. Phone # (_______)_________________

City, State, Zip _____________________________________ Insurance Group # _____________________________

Subscriber's Name __________________________________ Union Local # _________________________________

Subscriber's ID# ___________________________________ Birthdate ____/____/____

I give my consent to Michaud Periodontics and Dental Implants to release any of my dental records to my insurance companies, physician, general dentist or any other doctor related to my care. I authorize release of any information to my medical and/or dental insurance companies relating to services with Michaud Periodontics and Dental Implants. I authorize insurance payments to be directly made to Michaud Periodontics and Dental Implants.

Your present dentist ______________________________ City _____________________ How long? __________

Last tooth cleaning _______________________________________

Have you ever had previous periodontal (gum treatment)? Yes No

When and by whom ____

Why are you here today? ____

Name of physician _____________________________ City _______________________ Phone ______________

Check if you are allergic or have reacted adversely to any of the following?

Dental anesthetics (Novacaine, etc.)	Penicillin/Amoxcilin	Barbiturates, sedatives, or sleeping pills
Valium, Halcion, or other Benzodiazapenes	Codeine	Percodan / Percocet
Demerol	Vicodin	Keflex
Ibuprofen	Aspirin	Tylenol
Tetracycline	Erythromycin	Sulfa drugs
Sulfite preservatives	Latex	Sutures/stitches
Ciproflox/Klynda	Iodine	Other ________________________

Have you ever used intravenous (injected) bisphosphonates (*Zometa, Aredia, or Boniva*)?__________________________

Are you now using or ever used oral (pill) bisphosphonates (*Fosamax, Actonel, or Boniva*)?_________________________

Do you currently require an antibiotic premedication for dental appointments? ___________________________________

Are you on any special diet? ____

Do you currently smoke? Y / N Amount? ___________ Have you ever smoked? Y / N If yes, details: ______________

Smokeless tobacco / snuff? Y / N

Have you ever had extensive radiation therapy? ____

List all medications you are now taking (Rx, over the counter, or natural/herb supplements)_________________________

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Do you have or have you ever had any of the following diseases or problems? PLEASE CHECK IF YES:

Rheumatic fever	Rheumatic heart disease	Pacemaker	Heart murmur
Heart trouble	High blood pressure	Artificial heart valves	Artificial joints
Prostate disorders	Kidney disease	Liver disease	Hepatitis A / B / C
AIDS / HIV positive	Asthma	Tuberculosis	Respiratory (Lung) disease
Arthritis	Seizures or epilepsy	Alcoholism	Thyroid or parathyroid disorders
Drug addiction	Diabetes	Stomach ulcers	Osteoporosis/Osteopenia
Glaucoma	Hemophilia	Bleeding disorders	Sleep disorder
Sleep Apnea	Cancer	Anemia	Anxiety
Depression	Bi-Polar	Schizophrenia	

Please describe any other information you feel we should be aware of relative to your health: _______________________

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WOMEN:

Are you pregnant? Yes No If yes, expected delivery date ___________________

Do you think you might be pregnant? Yes No

Are you breast-feeding? Yes No

Are you taking female hormones (oral contraceptives, etc.)? Yes No

Both the above and on the reverse side are accurate.

____ **Date** _____/______/______

Signature (if patient is a minor, then parent or guardian)