Diane A. Slawinowski, D.D.S.

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PATIENT REGISTRATION FORM

PATIENT INFORMATION: Today's Date: _____

First Name: _____ Middle Initial: _____

Last Name: _____ Preferred Name: _____

Address: _____

P.O. Box/Apt. #: _____

City: _____

State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ Sex: Male Female

Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Social Security #: _____

Email: _____

I would like to receive correspondence via: ☐ E-mail ☐ Text

Emergency Contact: _____ Phone #: _____

PRIMARY INSURANCE INFORMATION:

Name of Insurance: _____

Group #: _____ ID #: _____

Employer:_____

POLICY HOLDER INFORMATION (IF NOT YOURSELF):

First Name: _____ Middle: ___ Last Name: _____

Birth Date: _____ Social Security #: _____ Relationship to Patient: _____

MEDICAL HISTORY:

Doctor's Name: _____

Phone: _____ Email: _____

Joint Replacement: Yes No If Yes, Date: _____ Doctor: _____

Since 2001, were you, treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget 's disease, Multiple Myeloma or metastatic cancer? Date treatment began: _____

Are you under a physician's/Specialists care now? Yes No

Have you been hospitalized or had a major operation? Yes No

Have you ever had a serious head or neck injury? Yes No

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

Explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other Bisphosphonates? Yes No

Are you on a special diet? Yes No Do you use tobacco? Yes No

Do you use controlled substances? Yes No

WOMEN: Are you pregnant? Yes No Trying to get pregnant? Yes No

Taking Oral Contraceptive Yes No

Allergies: Are you allergic to any of the following? Please specify the reaction:

Local anesthetics: Yes No Aspirin: Yes No

Penicillin or other antibiotics: Yes No Sulfa Drugs: Yes No

Barbiturates, Sedatives, or sleeping pills: Yes No

Codeine or other Narcotics: Yes No

Metals: Yes No Latex (Rubber): Yes No

Hay fever/Seasonal: Yes No Food: Yes No

Other: Yes No _____

Do you have or have you had any of the following? (Please circle all that apply and specify if necessary)

AIDS/HIV Positive	Anemia	Artificial Heart Valve
Abnormal Bleeding	Allergies	Artificial Joint
Alzheimer's Disease	Arthritis	Asthma

Autoimmune Disease

Blood Disease

Blood Transfusion

Breathing Problems

Bronchitis

Bruise Easily

Cancer

Cardiovascular Disease

Chemotherapy

Chest Pains

Cold Sores/Fever blisters

Congenital Heart Defect

Convulsions

Cortisone Medication

Congenital Heart Defect

Damaged Heart Valves

Diabetes

Drug Addiction

Eating Disorder

Epilepsy or Seizures

Excessive Bleeding

Frequent Cough

Frequent Headaches

Fainting spells/Dizziness

GE Reflux/Heartburn

Glaucoma

Hay Fever

Heart Attack/Failure

Heart Murmur

Heart Pacemaker

Heart Trouble/Disease

Hemophilia

Hepatitis A

Hepatitis B or C

Herpes

High Blood Pressure

High Cholesterol

Hives or Rash

Hypoglycemia

Irregular Heartbeat

Kidney Problems

Leukemia

Liver Disease

Low Blood Pressure

Lung Disease

Mitral Valve Prolapse

Osteoporosis

Pain in jaw joints

Radiation Treatments

Rheumatism/Rheumatoid Arthritis

Scarlet Fever

Sexually Transmitted Disease

Sickle Cell Disease

Sinus Trouble

Sleep Disorder

Spina Bifida

Shingles

Smoking/Vaping

Stomach/Intestinal Disease

Stroke

Thyroid Disease

Tonsillitis

Tuberculosis

Ulcers

Covid-19

Have you ever had any serious illness not listed above? Yes No If yes, please specify:

_____

DENTAL INFORMATION

What is the reason for your dental visit today? _____

Date of last dental exam? _____ Date of last dental x-rays? _____

Are you currently experiencing any dental pain or discomfort? Yes No

If yes, please explain: _____

Do your gums bleed when you brush or floss? Yes No

Are your teeth sensitive to cold, hot, sweets, or pressure? Yes No

Does food or floss catch between your teeth? Yes No

Is your mouth dry? Yes No

Have you had any periodontal (gum) treatments? Yes No

Have you ever had orthodontic (braces) treatment? Yes No

Have you had any problems associated with previous dental treatments? Yes No

Do you have any clicking, popping or discomfort in the jaw? Yes No

Have you ever had a serious injury to your head or mouth? Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient/parent/or guardian:

_____ Date: _____