



ADVANCE DENTISTRY

YOUR COMFORT IS OUR TOP PRIORITY

5823 Wooster Pike
Cincinnati, Ohio 45227

PATIENT REGISTRATION

Please Print

NAME OF PATIENT _____ M ___ F ___

ADDRESS _____

HOME PHONE _____ WORK _____ ext _____

CELL PHONE _____ PAGER NUMBER _____

E-MAIL ADDRESS _____

SS# _____ BIRTHDAY _____ MARITAL STATUS _____

HOW WERE YOU REFERRED? _____

EMPLOYER _____

OCCUPATION _____

NAME OF SPOUSE _____ BIRTHDAY _____ SS# _____

SPOUSE'S EMPLOYER _____

SPOUSE'S WORK PHONE _____ EXT _____ OCCUPATION _____

EMERGENCY CONTACT _____

DATE OF LAST VISIT _____ PURPOSE _____

PRIMARY DENTAL INSURANCE _____ POLICY # _____

SECONDARY DENTAL INSURANCE _____ POLICY # _____

PRIMARY MEDICAL INSURANCE _____ POLICY # _____

SECONDARY MEDICAL INSURANCE _____ POLICY # _____

I hereby authorize Scott E. Sayre, D.D.S. to share my personal health information with other physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care employees who are providing me treatment.

I also authorize Scott E, Sayre, D.D.S. to release any information acquired in the course of dental examination or treatment for insurance claim filing and authorize that payment for services rendered to me may be paid to the doctor. Photostat of this authorization shall be considered as effective and valid as the original.

There will be a charge of \$50.00 to forward x-rays from this office.

Patient Signature: _____ Date: _____

MEDICAL HISTORY

PHYSICIAN _____ PHONE _____ YOUR HEIGHT _____
PHYSICIAN ADDRESS _____ YOUR WEIGHT _____

CIRCLE THE FOLLOWING:

- Y N Have you been seen by a physician during the last year?
Y N Have you ever been told by a physician that you have a heart murmur?
Y N Females: Do you take oral contraceptives? Are you pregnant? ___
Y N Are you presently under medical care or taking any prescribed or over the counter medicine or drugs?
Please list any medications you are currently taking on the Medication Sheet.
Y N Have you ever had a prolonged illness or hospitalization?
Y N Have you ever had a surgery or radiation therapy?
Y N Have you ever had an adverse reaction from local anesthesia?
Y N Have you had a bad experience in a dental office?
Y N Are you allergic to any foods, clothing, animals, etc.?
Y N Do the following make you ill or are you allergic to:
Penicillin or Antibiotics _____ Aspirin _____
Barbituates _____ Narcotics (Demerol) _____
Sulfa Drugs _____ Codiene _____
Local Anesthetics _____ Any other drugs _____
Y N Do you smoke? How many packs / day? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- Y N Rheumatic fever/ Rheumatic heart disease
Y N Heart trouble (pacemaker)
Y N Mitral Valve Prolapse
Y N Heart attack
Y N Chest pain
Y N Shortness of breath
Y N High or low blood pressure
Y N Jaundice, hepatitis, or liver disease
Y N Kidney trouble
Y N Sexually transmitted disease / AIDS
Y N High risk category for AIDS
Y N A transfusion
Y N Vision or hearing impairment
Y N Tuberculosis
Y N Cancer
Y N Sugar diabetes or family history of
Y N Fatigue or night sweats
Y N Excessive thirst or urination
Y N Recent weight loss without dieting
Y N Anemia or blood disorder
Y N Serious bleeding or family history of
Y N Painful or swollen joints
Y N Prosthetic replacement (hip, knee, etc.)
Y N Thyroid disease
Y N Respiratory disorders
Y N Epilepsy or seizures
Y N Childhood diseases (chicken pox, measles, mumps)

LIST OTHER MEDICAL PROBLEMS: _____