COGGUILLO FAMILY DENTISTRY
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Phone: 203-874-0000 Fax: 203-874-4986

PATIENT REGISTRATION / HEALTH HISTORY

Patient Account No. Office use	Medical Alert Office use

Name of Patient ______________________ Phone ______________________

Address ______________________ City ______________ State ______ Zip ______

E-mail Address ______________________

Date of Birth ______________ M F Married Single Divorced

Social Security Number ______________ (Social Security No. is necessary for insurance purposes)

Name of Employer ______________________ Business Phone ______________

Employer Address ______________________ City ______________ State ______ Zip ______

INSURANCE INFORMATION

Primary Insurance Co. ______________________ Group ______________

Employee's Name ______________________ Employee's Date of Birth ______________

Employee's Social Security No. ______________________

Secondary Insurance Co. ______________________ Group No. ______________

Employee's Name ______________________ Employee's Date of Birth ______________

Employee's Social Security No. ______________________

EMERGENCY CONTACT

Name ______________________ Phone ______________

Address ______________________ City ______________ State ______ Zip ______

Relationship to Patient ______________________

Would you like to be reminded of your exam appointment? YES _____ NO _____

By Mail _______ By E-mail _______ By Phone _______ At Work _______ At Home _______

Referred to us by ______________________

CC200-4a

HEALTH HISTORY

1. Have you been under the care of a medical doctor during the past two years? Yes _______ No _______

   If yes, for what? ______________________________

   Physician's Name ______________________________ Phone ______________________________

   Address ______________________________ City ____________________ State ______ Zip ______________

2. Have you taken any medication or drugs during the past 2 years? Yes _______ No _______

3. Are you taking any medication, drugs or pills now? Yes _______ No _______

   If yes, please list name and dosage ______________________________

   ____

   ____

4. Are you aware of having an allergic (**or adverse reaction**) to any medication or substance? Yes ________ No ________

   If yes, please list: ______________________________

5. Have you been a patient in the hospital during the past five years? Yes ________ No ________

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Condition			Condition		
Heart (Surgery, Disease, Attack)	Yes	No	Asthma	Yes	No
Chest Pain	Yes	No	Hay Fever	Yes	No
Congenital Heart Disease	Yes	No	Latex Sensitivity	Yes	No
Heart Murmur	Yes	No	Allergies or Hives	Yes	No
High Blood Pressure	Yes	No	Sinus Trouble	Yes	No
Mitral Valve Prolapse	Yes	No	Radiation Therapy	Yes	No
Artificial Heart Valve	Yes	No	Chemotherapy	Yes	No
Heart Pacemaker	Yes	No	Tumors	Yes	No
Rheumatic Fever	Yes	No	Hepatitis		
Arthritis/Rheumatism	Yes	No	A (infectious) B (serum) C (virus)	Yes	No
Cortisone Medicine	Yes	No	Venereal Disease	Yes	No
Swollen Ankles	Yes	No	H. I. V. Positive	Yes	No
Stroke	Yes	No	Cold Sores/Fever Blisters	Yes	No
Diet (Special/Restricted)	Yes	No	Blood Transfusion	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Hemophilia	Yes	No
Kidney Trouble	Yes	No	Sickle Cell Disease	Yes	No
Ulcers	Yes	No	Bruise Easily	Yes	No
Diabetes	Yes	No	Liver Disease	Yes	No
Thyroid Problems	Yes	No	Yellow Jaundice	Yes	No
Glaucoma	Yes	No	Neurological Disorders	Yes	No
Contact Lenses	Yes	No	Epilepsy or Seizures	Yes	No
Emphysema	Yes	No	Fainting or Dizzy Spells	Yes	No
Chronic Cough	Yes	No	Nervous Disorders/Anxiety	Yes	No
Tuberculosis	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Do you use more than two pillows to sleep? Yes ________ No ________

8. Have you lost or gained more than 10 pounds in the past year? Yes ________ No ________

9. Do you have or have you had any disease, condition, or problem not listed? Yes ________ No ________

   If yes, please list: ______________________________

10. **Women:** Are you: **Pregnant?** Yes, ______ Months No **Nursing?** Yes______ No ______

    Taking birth control pills? Yes______ No______

DENTAL HISTORY

What is your reason for your visit today? ______________________________

____

Date of Last Dental Visit ______________________________

Last Dental Cleaning ______________________________

Last Full Mouth X-rays ______________________________

What was done at your last dental visit? ______________________________

____

Previous Dentist's Name ______________________________

Address ______________________ City ______________________ State ________ Zip ____________

Telephone ______________________________

How often do you have dental examinations? ______________________________

How often do you brush your teeth? ______________ How often do you floss? ______________

What other dental aids do you use? (interplak, toothpick, etc.) ______________________________

Do you have any dental problems now? Yes ________ No ________

If yes, please describe: ______________________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Signature ______________________________ Date ______________________
(or guardian, if patient is a minor)

Do Not Write Below this Line.

Review

Dentist's Signature ______________________________ Date ______________________