Patient Registration

Dr. Peter F. Hazim 105 N. Alma Dr.Ste 100 Allen, Tx. 75013

First Name | Middle Initial | Last Name | Preferred Name

Date of Birth MM/DD/YY | SSN | Sex/Gender

Marital Status: Married Divorced Single Widowed Separated Child

Address Line 1

City | State | Zip Code

Home Phone | Work Phone/Ext.

Cell Phone | Email

Responsible Party If the patient has a responsible party, please enter their details

First Name | Middle Initial | Last Name

Date of Birth | SSN | Sex/Gender

Relationship to Patient: Self Parent Spouse Other

Marital Status: Married Divorced Single Widowed Separated

Phone | Work Phone | Cell Phone

Address Line 1

City | State | Zip

Patient Signature | Date:

Patient Name (First,Last):_____ DOB:_____

Dental History

Date: _____

Reason for your visit: _____

If new to our practice, who may we thank for referring you?

_____

If new to our practice, when was your last dental visit: _____

With Dr.:_____

What type of toothbrush do you use? Soft Medium Hard Electric

Please answer each question listed below:

Do you feel pain to any of your teeth while brushing or flossing? Yes No

Are your teeth sensitive to cold, hot, sweet, sour foods or any liquids? Yes No

Have you noticed any loosening of your teeth? Yes No

Do your gums bleed while flossing? Yes No

Does food become caught between your teeth? Yes No

Do you have any sores or lumps in or near your mouth? Yes No

Have you had orthodontic treatment (braces)? Yes No

Have you ever had any oral surgery? Yes No

Have you ever worn a bite plate or other appliance? Yes No

Have you ever experienced any of the following problems with your jaw:

- ☐ Clicking/Popping
- ☐ Jaw Pain
- ☐ Jaw Locking
- ☐ Difficulty Opening/Closing
- ☐ Difficulty Eating
- ☐ Clench or Grind Teeth?
- ☐ Swelling?
- ☐ Jaw Fatigue

Employee Initials: _____

Patient Name (First,Last):_____ DOB:_____

Have you ever experienced any of these other general symptoms? : (check the ones that apply)

- ☐ Headaches
- ☐ Ear/Sinus Congestion
- ☐ Throat Pain
- ☐ Ringing in Ears
- ☐ Hearing Changes
- ☐ Visual Symptoms
- ☐ Eye Pain
- ☐ Back Pain
- ☐ Muscle Spasms
- ☐ Neck Aches
- ☐ Shoulder Pain
- ☐ Difficulty Sleeping
- ☐ Dizziness
- ☐ Other?

Medical History

Are you in good health? Yes No
Have there been any changes in your general health within the past year? Yes No
Are you pregnant? Yes No
If pregnant, are you nursing? Yes No
Have you been hospitalized in the last 3 years? Yes No
If yes, please explain:

_____

Are you currently taking any medications? Yes No

If yes, list here:_____

_____

Allergies? (Check the ones that apply)

- ☐ Anesthetic
- ☐ Antihistamines
- ☐ Benzocaine
- ☐ Ceftin
- ☐ Clindamycin
- ☐ Codeine
- ☐ Dilaudid
- ☐ Epinephrine
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Latex
- ☐ Omnicef
- ☐ Penicillin
- ☐ Propranolol
- ☐ Sulfa Drugs
- ☐ Tetracycline

Do you have any allergies not listed? Yes No

If yes, list here: _____

Employee Initials: _____

Patient Name (First,Last):_____ DOB:_____

Medical Conditions? (Check the ones that apply)

- ☐ A FIB
- ☐ Abnormal Bleeding
- ☐ Acid Reflux
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Arthritis
- ☐ Artificial Valve
- ☐ Asthma
- ☐ Blood Clot
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ C. Diff
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blisters
- ☐ Depression
- ☐ Diabetes
- ☐ Drug/Alcohol Dependence
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy/Seizure
- ☐ Fainting
- ☐ Frequent Nose Bleeds
- ☐ Glaucoma
- ☐ Hardening of Arteries
- ☐ Heart Condition
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemochromatosis
- ☐ Hepatitis A, B, C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hives or Skin Rash
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Lung/Breathing Problems
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Parkinson's
- ☐ Persistent Cough
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Short of Breath
- ☐ Sjogren's
- ☐ Skin Cancer
- ☐ Sleep Apnea
- ☐ STD
- ☐ Stroke
- ☐ Swelling of the Ankles
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Ulcerative Colitis

Do you have any disease, condition, or problem not listed above that you think we should know about? Yes No

If yes, list here: _____

Do you use alcohol? Yes No

Do you use Tobacco Products? Yes No

Patient Signature Date

Employee Initials: _____