# Parks Avenue Dental

Dr. Darlene Guttridge
313 Parks Avenue, Scottsboro, AL 35768
(256) 259-1746

## Patient Registration

**PATIENT DETAILS** Date: _______________

First Name:* _______________ Middle Name: _______________ Last Name:* _______________

Date of Birth:* _______________ Social security number: _______________

Address:* _______________________________________________

City:* _______________ State:* _______________ Zip:* _______________

Email: ______________________________ Home Phone Number : _______________

Cell Phone Number:* _______________ Work Phone Number : _______________

Gender: ○ Male ○ Female

Marital Status: ○ Minor ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

**CONTACT INFORMATION**

Spouse or Parents/Guardians Name: ______________________________

Employer: ______________________________

Email: ______________________________ Home Phone Number : _______________

Cell Phone Number: _______________ Work Phone Number : _______________

Whom can we thank for referring you? ______________________________

Person to contact in case of emergency: *______________________________

Do you consent to receiving any updates/appointment reminders via text/email? ○Yes ○No

**RESPONSIBLE PARTY INFORMATION**

Relationship to Patient*______________________________

First Name*_______________ Middle Name _______________ Last Name *_______________

Date of Birth *____________ Address * _______________________________________________

City * _______________ State * _______ Zip * ____________

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## PRIMARY INSURANCE INFORMATION

### Policy Holder Information:

Relationship to Patient*______________________________

First Name*_______________ Middle Name _______________ Last Name *_______________

Date of Birth *____________ Address * ______________________________________________

City * _______________ State * ______ Zip * ____________

Employer Name ________________________ Insurance Company Name ____________

Insurance Company Phone Number ____________ Group Number ____________

## SECONDARY INSURANCE INFORMATION

### Policy Holder Information:

Relationship to Patient*______________________________

First Name*_______________ Middle Name _______________ Last Name *_______________

Date of Birth *____________ Address * ______________________________________________

City * _______________ State * ______ Zip * ____________

Employer Name ________________________ Insurance Company Name ____________

Insurance Company Phone Number ____________ Group Number ____________

Patient Signature: _________________________________________x Date: ____/____/_____

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## Medical History and Dental History

### PATIENT DETAILS

First Name* ______________ Middle Name ______________ Last Name * ______________

Date of Birth * ______________

Gender ○ Male ○ Female Marital Status ______________

### HEALTH HISTORY

Are you currently under the care of a physician? ○Yes ○No
Physician Name:
Physician Phone Number:

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Have you ever been hospitalized or had a major operation? ○Yes ○No
If yes, please explain:

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Are you taking any blood thinners? ○Yes ○No
If yes, please explain:

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Have you undergone placement of any metal rods, pins, or joints? ○Yes ○No
If yes, please explain:

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Have you ever had a serious head or neck injury? ○Yes ○No
If yes, please explain:

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Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
If yes, please explain: ○Yes ○No

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Do you use tobacco in any form? ○Yes ○No
If yes, please explain:

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Do you use controlled substances? ○Yes ○No
If yes, please explain:

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Are you on a special diet? * ○Yes ○No
If yes, please explain:

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## MEDICAL HISTORY

Do you have, or have you had any of the following medical conditions?

- ☐ **Anemia**
- ☐ **Artificial Joints**
- ☐ **Asthma**
- ☐ **Cancer**
- ☐ **Diabetes**
- ☐ **Drug Addiction**
- ☐ **Emphysema**
- ☐ **Fainting**
- ☐ **Head Injuries**
- ☐ **Hepatitis B**
- ☐ **High Blood Pressure**
- ☐ **Jaundice**
- ☐ **Liver Disease**
- ☐ **Nervous Disorders**
- ☐ **Pregnancy**
- ☐ **Respiratory Problems**
- ☐ **Rheumatism**
- ☐ **Stomach Problems**
- ☐ **Tuberculosis**
- ☐ **Ulcers**
- ☐ **Arthritis**
- ☐ **Artificial Heart Valve**
- ☐ **Blood Disease**
- ☐ **Chemotherapy**
- ☐ **Dizziness**
- ☐ **Epilepsy**
- ☐ **Excessive Bleeding**
- ☐ **Glaucoma**
- ☐ **Heart Disease**
- ☐ **Hepatitis C**
- ☐ **HIV/AIDS**
- ☐ **Kidney Disease**
- ☐ **Mental Disorders**
- ☐ **Pacemaker**
- ☐ **Radiation Treatment (head/neck)**
- ☐ **Rheumatic Fever**
- ☐ **Seizures**
- ☐ **Stroke**
- ☐ **Tumors**

☐ **Other**

If you answered "Other" please specify/explain:

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Do you have allergies to any of the following?

- ☐ **Aspirin**
- ☐ **Acrylic**
- ☐ **Codeine**
- ☐ **Latex**
- ☐ **Local Anesthetics**
- ☐ **Metal**
- ☐ **Penicillin**
- ☐ **Sulfa Drugs**
- ☐ **Other:**

If you answered "Other" please specify/explain:

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Please list medications you are currently taking:

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Is there any other medical or dental information we should know about?

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Please check any of the following that apply to you:

☐ **Sensitivity (hot/cold/sweet)**
☐ **Jaw pain**
☐ **Mouth ulcer or cold sores**
☐ **Grinding or clenching teeth**
☐ **Bleeding Gums**
☐ **Bad breath**

**Do you have any of the following:**

☐ **Dentures**
☐ **Partial Dentures**
☐ **Braces**
☐ **Gum treatments**

**Name of Previous Dentist:**

**City:** **State:**

**Date of last cleaning:**

**Date of last complete Xrays:**

**Why did you leave your last dentist?**

**What is the most important thing to you about your future smile?**

**What is the most important thing to you about your dental visit today?**

Patient Signature: ________________________________________x Date: ____/____/______