ACE DENTAL SPECIALISTS, PLLC ENDODONTICS
262 Cottage Street, Suite 302 • Littleton, NH 03561

PATIENT REGISTRATION & HEALTH HISTORY

PATIENT INFORMATION

Patient Name: ______________________________ Date: ______________

Address: ____

Email: ______________________________ Gender: ______________

Date of Birth: ______________ Is the patient a minor (under 18)? Yes ☐ No ☐

Home Phone: ______________ Cell: ______________ Work: ______________

IN CASE OF EMERGENCY , PLEASE CONTACT: ______________________________

Relationship to Patient: ______________ Emergency Contact Number(s): ______________

DENTAL INSURANCE

Subscriber's Name: ____

Subscriber's Date of Birth: ______________ Subscriber's Social Security #: ______________

Relationship to Patient: ____

Insurance Company: ______________________________ Subscriber ID: ______________

Is the patient covered by additional insurance? Yes ☐ No ☐

Secondary Insurance Company: ______________________________ Subscriber ID: ______________

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with the above named Insurance Company(ies) and assign directly to Ace Dental Specialists all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Ace Dental Specialists may use my healthcare information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________________ ______________________________
Signature of Responsible Party Relationship to Patient

______________________________ ______________________________
Printed Name Date

HEALTHCARE INFORMATION

General Dentist: ______________ Reason for today's visit: ______________

Physician's Name: ______________________________ Physician Phone: ______________

DENTAL HISTORY

PLEASE CHECK THE BOX TO INDICATE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Chewing tobacco
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collecting between teeth
- ☐ Foreign objects
- ☐ Grinding or clenching teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain during brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Smoking / Vaping
- ☐ Sores or growths in your mouth

HOW OFTEN DO YOU FLOSS? ____________________ HOW OFTEN DO YOU BRUSH? ____________________

HEALTH HISTORY

Do you need to take antibiotics prior to receiving dental care? ☐ Yes ☐ No ☐ Don't know

If Yes, for what condition: ____________________ Name of antibiotic: ____________________ Dosage: __________

Have you ever used a bisphosphonate medication? (Fosamax, Actonel, Atelvia, Didronel, Boniva) ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Apidex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)? ☐ Yes ☐ No

Have you ever been exposed to or tested positive for COVID-19 (Coronavirus)? ☐ Yes ☐ No ☐ Don't know

PLEASE CHECK THE BOX TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

CARDIAC ISSUES

- ☐ Angina Pectoris
- ☐ Artificial Heart Valves
- ☐ Congenital Heart Lesion
- ☐ Heart Murmur/Mitral Valve Prolapse
- ☐ Heart Attack/Myocardial Infarction
- ☐ Heart Failure
- ☐ Heart Surgery
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pacemaker/AICD
- ☐ Rheumatic/Scarlet Fever
- ☐ Stroke

BLOOD DISORDERS

- ☐ Anemia
- ☐ Bleeding Abnormalities
- ☐ Hemophilia
- ☐ Sickle Cell Anemia

RESPIRATORY

- ☐ Cough
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Tuberculosis

CANCER-RELATED

- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Tumor or Unusual Growth
- ☐ Weight Loss, Unexplained

CHRONIC CONDITIONS

- ☐ Acid Reflux/Heartburn
- ☐ Arthritis, Rheumatoid/Osteo
- ☐ Artificial Joints/Prostheses
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Glaucoma, Type ____________
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Substance Use Disorder
- ☐ Thyroid Problems, Type ________

INFECTIOUS DISEASE

- ☐ AIDS/HIV
- ☐ Hepatitis, Type ____________
- ☐ Herpes/Cold Sores
- ☐ Skin Rash
- ☐ Swollen Neck/Glands
- ☐ Tuberculosis
- ☐ Venereal Disease

NEUROLOGICAL/COGNITIVE

- ☐ Anxiety
- ☐ Depression
- ☐ Dementia
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizziness/Vertigo
- ☐ Headaches, Type ____________
- ☐ Paralysis/Weakness
- ☐ Psychiatric Care

PAIN CONDITIONS

- ☐ Acute, Type ____________
- ☐ Chronic, Type ____________
- ☐ **OTHER** Conditions not listed:

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____

FOR WOMEN

- ☐ Pregnant, # weeks: __________
- ☐ Nursing
- ☐ Taking Oral Contraception

MEDICATIONS

Pharmacy Name: ______________________ Phone Number: ______________

Pharmacy Address: ______________________

Please list any medications you are currently taking (including herbal supplements) and the correlating condition:

MEDICATION	CONDITION	DOSAGE

ALLERGIES

PLEASE CHECK THE BOX TO INDICATE IF YOU HAVE AN ALLERGY TO ANY OF THE FOLLOWING:

- ☐ Acetaminophen (Tylenol)
- ☐ Codeine
- ☐ Local Anesthetics
- ☐ Latex
- ☐ NSAIDS (Ibuprofen, Advil, Naproxen, Naprosyn)
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other (please list below)

If you checked yes to any of the above, please describe the nature of your allergic reaction below:

____

____

____

NOTES:

B.P. ________ / ________ mmHg, Pulse ________ bpm, Temp _______°F

______________________ ____/____/____

Anitha AbdulRahiman, DMD MMSc Date