THE OHIO STATE UNIVERSITY COLLEGE OF DENTISTRY
PATIENT REGISTRATION INFORMATION
PLEASE PRINT LEGIBLY

Today's Date: _____ ☐ **NEW PATIENT** ☐ **PREVIOUS PATIENT**

Patient Information

First Name: _____ Last Name: _____ Middle Name: _____

Dr. Mr. Mrs. Ms. (Please circle one) Nickname: _____

SSN: ____/____/_____

Birth Date: ____/____/____ Gender: ☐ M ☐ F
Month Day Year

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

E-Mail: _____ Cell Telephone: (____)_____

Work Telephone: (____)_____ Extension: _____ Preferred Call Times: _____
Area code

Home Telephone: (____)_____ Can you be Contacted at Work: ☐ Yes ☐ No
Area code

Language: ☐ English ☐ Spanish ☐ French ☐ Other _____

Race: ☐ Caucasian ☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ Other

Employment Status: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Other

School Patient Attends: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

In Case of Emergency, Please Notify

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: (____)_____ Work Telephone: (____)_____
Area code Area code

Pager: (____)_____ Cell Telephone: (____)_____
Area code Area code

Signature _____ Date _____

(CONTINUED ON BACK)

Person responsible for payment (if different from first page)

Personal Information

First Name: _____ Last Name: _____ Middle Name: _____

Dr. Mr. Mrs. Ms. (Please circle one) Nickname: _____

SSN: _____/_____/_____

Birth Date: _____/_____/_____ Gender: ☐ M ☐ F
Month Day Year

Please Indicate below the address and phone number where you can be contacted

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

E-Mail: _____ Cell Telephone: (_____)_____

Work Telephone: (_____)_____ Extension: _____ Preferred Call Times: _____
Area code

Home Telephone: (_____)_____
Area code

Please check appropriate box

Employment Status: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____

Other Information

Please list other family members seen in our office: _____

Referring Doctor(s) Name: _____ Telephone: (_____)_____
Area code

Whom may we thank for referring you to our office? _____

Signature _____ Date _____

INSURANCE INFORMATION

Patient Name: _____ Today's Date: _____
(first) (last)

Primary Dental Insurance None ☐

Effective Date: _____

Dental Insurance Carrier: _____ Telephone Number: (___) _____
Area code

Claims Mailing Address: _____

City: _____ State: _____ Zip: _____

SUBSCRIBER INFORMATION:

Subscriber Name: _____ Birth Date: ___/___/___
Month Day Year

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Street Address: _____ City: _____ State: _____ Zip: _____

Group or ID Number: _____ SSN: ___/___/___

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Secondary Dental Insurance None ☐

Effective Date: _____

Dental Insurance Carrier: _____ Telephone Number: (___) _____
Area code

Claims Mailing Address: _____

City: _____ State: _____ Zip: _____

SUBSCRIBER INFORMATION:

Subscriber Name: _____ Birth Date: ☐
Month Day Year

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Street Address: _____ City: _____ State: _____ Zip: _____

Group or ID Number: _____ SSN: ___/___/___

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Medicaid Number: _____

Columbus Health Plan Number: _____

Referring Doctor Name(s): _____ Telephone Number: (___) _____
Area code

Address: _____ City: _____ State: _____ Zip: _____

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INSURANCE INFORMATION -continued

Patient Name: _____ Today's Date: _____
(first) (last)

Primary Medical Insurance **None** ☐

Effective Date: _____

Medical Insurance Carrier: _____ Telephone Number: (___) _____
Area code

Claims Mailing Address: _____

City: _____ State: _____ Zip: _____

SUBSCRIBER INFORMATION:

Subscriber Name: _____ Birth Date: ___/___/___
Month Day Year

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Street Address: _____ City: _____ State: _____ Zip: _____

Group or ID Number: _____ SSN: ___/___/___

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Secondary Medical Insurance **None** ☐

Effective Date: _____

Medical Insurance Carrier: _____ Telephone Number: (___) _____
Area code

Claims Mailing Address: _____

City: _____ State: _____ Zip: _____

Subscriber Information

Subscriber Name: _____ Birth Date: ___/___/___
Month Day Year

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Street Address: _____ City: _____ State: _____ Zip: _____

Group or ID Number: _____ SSN: ___/___/___

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Medicaid Number: _____

Columbus Health Plan Number: _____

Referring Doctor Name(s): _____ Telephone Number: (___) _____
Area code

Address: _____ City: _____ State: _____ Zip: _____

THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

College of Dentistry
Adult Medical History

Patient Name: _____ Date of Birth _____ Today's Date _____
Last *First* *M.I.*

PLEASE SELECT THE CORRECT ANSWER

Y	N	GENERAL
		HEIGHT _____ FT _____ IN
		WEIGHT _____ LBS
		GENERAL HEALTH STATUS (CHOOSE ONE): ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
☐	☐	ARE YOU UNDER PHYSICIAN'S CARE?
☐	☐	HAVE YOU BEEN HOSPITALIZED IN THE PAST 10 YEARS?
☐	☐	HAVE YOU HAD ANY EMERGENCY ROOM VISITS IN THE PAST 10 YEARS?
☐	☐	HAS YOUR DOCTOR LIMITED YOUR ACTIVITY?
☐	☐	CAN YOU CLIMB TWO FLIGHTS OF STAIRS WITHOUT REST?

PLEASE ANSWER "YES" OR "NO" FOR ANY CONDITIONS THAT YOU HAVE NOW, OR HAVE HAD IN THE PAST

Y	N	CARDIOVASCULAR / HEMATOLOGIC
☐	☐	DO YOU HAVE ANY HEART, CIRCULATORY OR BLOOD PRESSURE CONDITIONS?
☐	☐	HEART ATTACK (MI)
☐	☐	CONGESTIVE HEART FAILURE (CHF)
☐	☐	ANGINA (CHEST PAIN)
☐	☐	HEART SURGERY / STENT / VALVE REPLACEMENT
☐	☐	HYPERTENSION (HIGH BLOOD PRESSURE)
		IF YES, WHAT IS YOUR USUAL BLOOD PRESSURE? _____
☐	☐	ARRHYTHMIA
☐	☐	PACEMAKER/ICD
☐	☐	OTHER HEART CONDITIONS: _____

Y	N	PULMONARY
☐	☐	DO YOU HAVE ANY LUNG OR BREATHING CONDITIONS?
☐	☐	ASTHMA
☐	☐	CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)
☐	☐	OTHER LUNG OR BREATHING CONDITIONS: _____

Y	N	NERVOUS SYSTEM
☐	☐	DO YOU HAVE ANY NERVOUS SYSTEM CONDITIONS?
☐	☐	SEIZURES - **IF YES**, PLEASE CHOOSE WHICH TYPE: ☐ ABSENCE ☐ GRAND MAL ☐ PETIT MAL ☐ OTHER
☐	☐	STROKE/TIA - **IF YES**, PLEASE CHOOSE WHICH TYPE: ☐ HEMORRHAGIC ☐ OCCLUSIVE
☐	☐	SYNCOP (FAINTING)
☐	☐	OTHER NEUROLOGICAL (NERVE) CONDITIONS? _____

Y	N	GASTROINTESTINAL / LIVER / BLOOD / METABOLIC
☐	☐	DO YOU HAVE ANY GASTROINTESTINAL, LIVER, BLOOD OR METABOLIC CONDITIONS?
☐	☐	HEPATIC (LIVER) DISEASE
☐	☐	HEPATITIS
☐	☐	RENAL (KIDNEY) DISEASE
☐	☐	UNUSUAL BLEEDING
☐	☐	SICKLE CELL ANEMIA / TRAIT
☐	☐	DIABETES - **IF YES**, PLEASE CHOOSE WHICH TYPE: ☐ I ☐ II
☐	☐	GASTROINTESTINAL (G.I.) DISEASE OR CONDITION
☐	☐	THYROID DISEASE

Y	N	INFECTIOUS DISEASES
☐	☐	DO YOU HAVE ANY INFECTIOUS DISEASES?
☐	☐	TUBERCULOSIS (TB)
☐	☐	HIV / AIDS - VIRAL LOAD _____ CD4 COUNT _____
☐	☐	HEPATITIS B
☐	☐	OTHER INFECTIOUS OR IMMUNE CONDITIONS: _____

Y	N	ORTHOPEDIC / MUSCULOSKELETAL
☐	☐	DO YOU HAVE ANY ORTHOPEDIC OR MUSCULOSKELETAL DISEASE?
☐	☐	BONE PROBLEMS OR DISEASES (OSTEOPOROSIS, OTHERS)
☐	☐	ARTIFICIAL JOINTS
☐	☐	ARTHRITIS - **IF YES**, PLEASE CHOOSE WHICH TYPE: ☐ OSTEOARTHRITIS ☐ RHEUMATOID ARTHRITIS ☐ OTHER
☐	☐	MUSCLE PROBLEMS OR DISEASES _____
☐	☐	JAW OR JAW JOINT PROBLEMS (TMD)

Y	N	OTHER
☐	☐	DO YOU HAVE ANY OTHER MEDICAL CONDITIONS?
☐	☐	PREGNANT OR NURSING IF PREGNANT, EXPECTED DELIVERY DATE _____
☐	☐	CANCER AND CANCER TREATMENT **IF YES**, WHAT TYPE/LOCATION _____
☐	☐	EMOTIONAL/PSYCHIATRIC DISORDERS _____
☐	☐	FREQUENT SINUS INFECTIONS (SINUSITIS)
☐	☐	SLEEP APNEA
☐	☐	DO YOU HAVE THE SYMPTOMS BELOW? ☐ SNORE LOUDLY ☐ OFTEN TIRED, FATIGUED, OR SLEEPY ☐ OBSERVED TO STOP BREATHING OR CHOKE/GASP IN YOUR SLEEP ☐ BEING TREATED FOR HIGH BLOOD PRESSURE ☐ NECK SIZE (SHIRT COLLAR) OVER 17" (MEN) OR 16" (WOMEN)

Y	N	SOCIAL
☐	☐	HAVE YOU EVER CONSUMED ALCOHOL OR USED RECREATIONAL DRUGS?
☐	☐	DO YOU CONSUME ALCOHOLIC BEVERAGES? **IF YES.....** HOW MANY TIMES IN THE PAST YEAR HAVE YOU HAD 4 (WOMEN), 5 (MEN) OR MORE DRINKS IN A SINGLE DAY? _____
☐	☐	DO YOU USE RECREATIONAL DRUGS?
☐	☐	HAVE YOU EVER SMOKED CIGARETTES? FOR HOW MANY YEARS? _____ HOW MANY PACKS PER DAY? _____
☐	☐	ARE YOU A FORMER SMOKER? **IF YES**, WHEN DID YOU QUIT? MONTH _____ YEAR _____
☐	☐	HAVE YOU EVER USED TOBACCO (OTHER THAN CIGARETTES)? **IF YES**, WHAT TYPE? _____
☐	☐	DO YOU USE ELECTRONIC CIGARETTES?
☐	☐	DO YOU HAVE PROBLEMS OR CONDITIONS NOT LISTED ABOVE? _____
☐	☐	DO YOU HAVE A CONDITION REQUIRING ACCOMMODATION? _____

MEDICATIONS AND ALLERGIES

LIST ANY CURRENT OR RECENT MEDICATIONS YOU TAKE:

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES OR REACTIONS TO ANY MEDICINES?

MEDICINE: _____

REACTION: _____

MEDICINE: _____

REACTION: _____

MEDICINE: _____

REACTION: _____

MEDICINE: _____

REACTION: _____

I certify that the above information is complete and accurate to the best of my knowledge. I understand that providing incomplete or inaccurate information may negatively influence my treatment and my treatment results.