CHRISTINA H. VY, D.M.D
Tel: 503-762-2500

PATIENT REGISTRATION FORM

Patient Name _____ Date_____ Referred by: _____

Home address _____Email: _____
Street City Zip

Male ☐ Female ☐ DOB _____ SS#_____ Occupation _____

Home Phone _____ Work Phone _____Cell Phone _____

EmergencyContact:_____ Phone _____

INSURANCE INFORMATION Dental Insurance Yes No Dual Insurance Yes No
****Please give insurance card to receptionist****

MEDICAL HISTORY
(Please circle)

Yes No Are you currently undergoing medical treatment of any kind? _____
Name & Phone # of your physician _____
Yes No Are you **sensitive or allergic** to latex, penicillin, novocaine, codeine, aspirin, sulfa or any other medications? _____
_____
Yes No Do drugs make you feel nauseated? _____
Yes No Have you had any problems with previous dental treatment? _____
Yes No Have your teeth been difficult to numb in the past? _____
Yes No Are you subject to prolonged bleeding? _____
Yes No Have you ever **had artificial prosthesis, hip replacement, heart valve, other**? _____
Yes No Have you ever taken **Bisphosphonate drugs (Fosamax, Actonel, Zometa**) for Osteoporosis or Cancer treatment? __
Yes No Female patients: Are you pregnant or Breastfeeding? Month due: _____

Do you have or have you had [circle]		**If yes, when?**			
Asthma	Heart trouble	Sinus problems	Arthritis	Diabetes	Allergies
Angina	Heart Murmur	Tuberculosis	Bleeding disorders	Ulcers/Colitis	Cancer
Stroke	High blood pressure	Glaucoma	Epilepsy	Rheumatic Fever	
Kidney disease	Liver Disease/Hepatitis	HIV/AIDS	Alcohol/Drug Dependence		

Please list any medications you are currently taking, including over the counter medications. Please indicate the dosage.

_____

_____

Do you have any illness not listed? _____

DENTAL HISTORY

What is your present dental problem? _____

Yes No Have you ever had root canal treatment before? How long ago? _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Patient's (or Legal Guardian's) Signature _____ Date: _____

Doctor/Administrative Staff Notes: **Reviewed By:_____**

_____

_____