Patient Registration

Welcome to Carolinas Dental Center! Please take a moment and fill out the information below:

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

Preferred Name_____ **Sex**: Male Female

Email_____ **Status**: Single Married Child

Date of Birth_____ **SSN**_____

Home Address: _____

City_____**State**_____**Zip**_____

Phone: Home_____ **Work**_____ **Mobile**_____

Best way to confirm your appointment: Email Text Call All None

Name of Employer_____Occupation_____

Business Address: _____

City_____State_____Zip_____

What are your hobbies or special interests? _____

How did you hear of Carolinas Dental Center: _____

Patient Signature_____ **Date**_____

*If patient was assisted with this form, please print name and sign below:

Print name of person assisting_____ Date_____

Signature of person assisting_____

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2514 Cuthbertson Road, Suite A • Waxhaw, NC 28173 • (704) 243-1122
www.CarolinasDentalCenter.com

Medical History

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No Date of last physical_____

Name of physician_____ Phone_____

Are you pregnant or think you may be? ……	Yes	No	If yes, expected delivery date_____
Are you nursing?……..	Yes	No	
Are you taking birth control pills? ……..	Yes	No	
Do you smoke or use tobacco products? ……	Yes	No	If yes, how much? _____
Are you taking anything for osteoporosis, such as Fosamax	Yes	No	If yes, please list below.
Are you taking any kind of blood thinning medication?	Yes	No	If yes, please list below.

Please list below any medications you are currently on:

_____taken for_____ _____taken for_____

_____taken for_____ _____taken for_____

_____taken for_____ _____taken for_____

Have you ever had (circle all that applies):

Abnormal blood pressure……	High	Low	No	Heart surgery……	Yes	No
AIDS or HIV……	Yes		No	Hepatitis……	Yes	No
Allergies……	Yes		No	Jaundice……	Yes	No
Anemia……..	Yes		No	Joint replacement/implant……..	Yes	No
Arthritis……..	Yes		No	Kidney trouble……..	Yes	No
Asthma/Hay Fever……	Yes		No	Lymph node enlargement……	Yes	No
Back problems……..	Yes		No	Mental health care……..	Yes	No
Blood transfusion……..	Yes		No	Mitral valve prolapse……..	Yes	No
Cancer……	Yes		No	Night sweats……..	Yes	No
Chemical dependency……..	Yes		No	Pacemaker……..	Yes	No
Cold sores/Fever blisters……..	Yes		No	Persistent diarrhea……..	Yes	No
Congenital heart lesions……	Yes		No	Prolonged bleeding……..	Yes	No
Diabetes……	Yes		No	Rheumatic fever……..	Yes	No
Drastic weight loss……	Yes		No	Sexually transmitted disease……	Yes	No
Eating disorders…….	Yes		No	Sinus trouble……..	Yes	No
Epilepsy/Seizures……	Yes		No	Stroke……..	Yes	No
Excessive urination/thirst……	Yes		No	Swollen ankles……..	Yes	No
Fainting spells…….	Yes		No	Thyroid problems……	Yes	No
Glaucoma……..	Yes		No	Tuberculosis or lung disease……..	Yes	No
Heart disease…….	Yes		No	Ulcers……	Yes	No
Heart murmur……	Yes		No	X-ray treatment for cancer……..	Yes	No

If you answered "yes" to any of the above please explain: _____

_____

Are you allergic to or have you had reactions to:

Local anesthetics like Novocain……..	Yes	No	Aspirin……..Yes	No	
Penicillin or other antibiotics……	Yes	No	Latex/Rubber……	Yes	No
Sulfa drugs…….	Yes	No	Any metal (gold, nickel, etc.)……..	Yes	No
Barbiturates, sedatives, sleeping pills……	Yes	No	Other (please list) _____		

*Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms and release Carolinas Dental Center to utilize any dental photographs for lecturing and educational purposes.

Signature_____ Date_____