PATIENT REGISTRATION

SHUNGA FAMILY DENTAL CARE

Date: _____/_____/_____

Shunga Family Dental Care, PA
5100 SW 28th Street
Topeka, Kansas 66614

Name: _____ Date of Birth _____/_____/_____
(Last) (First) (Middle)

Social Security #: _____-_____-_____ Sex: M F Pronouns: _____ Marital Status: S M D W

Address: _____ City_____ State/Zip_____

Phone Number: (h/w/c) _____ (h/w/c) _____

Email: _____ Employer: _____

May we contact you regarding upcoming appointments and/or reminders via ☐ Email and/or ☐ Text Message

In event of emergency, please contact: _____Phone:_____ _____Relationship:__ _____

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

Person Responsible for account: Self Other (please complete):

Name: _____ City/State/Zip _____

Phone: _____SSN:_____-____-_____ Relationship to Patient _____

Dental Insurance: _____
(Company) (Policy #/Group #) (Address) (Phone)

Name of Insured (if different from patient or responsible party): _____

Insured SSN _____-_____-_____ Insured DOB _____/_____/_____

Dental History:

When was your last dental visit? ____/____/____ For: _____ Where: _____

Are you uncomfortable at this time? Y N Dental Complaints (circle all that apply): Bleeding gums, Changing bite, Clenching/grinding, Sore jaws, Food packing between teeth, Sensitive to: cold heat pressure sweets

Notes: _____

_____

Have you ever had an adverse reaction to local anesthetics? Y N _____

Appearance: Are you happy with your smile? Y N

If not, what would you change? color shape spacing other _____

Do you have any questions about dentistry that we could answer for you? _____

_____

Please explain what you do to take care of your teeth/gums/mouth: _____

(Please turn over for medical history)

Patient's Physicians: Primary Care _____

Specialist(s) _____

Last physical exam: ___/___/___ Findings: _____

Are you being treated by a physician now? _____

_____

Have you been hospitalized recently? _____

_____

Have you had any recent serious illness? _____

Medications:

Prescription Medications	Amount	#Day	Over the counter products	Amount	#Day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Known Allergies: _____

Do you use tobacco? Y N How much? _____

Do you use alcohol? Y N How much? _____

Other habitual substances? Y N How much? _____

Do you have a history of:	**Y**	**N**		**Y**	**N**		**Y**	**N**
Heart Problems	____	____	Kidney disease	____	____	Cancer	____	____
Heart Valve Replacement	____	____	Genital/Urinary tract problems	____	____	type _____		
Angina or Chest Pain	____	____	Sexually Transmitted Disease	____	____	Chemo or Radiation Therapy	____	____
Heart Murmur	____	____	Positive HIV test / AIDS	____	____	Other Therapy _____		
Rheumatic Fever	____	____	Stomach/Intestinal problems	____	____	_____		
Swelling in Ankles	____	____	Other Digestive Problems	____	____	**Males:**		
Arteriosclerosis	____	____	GERD	____	____	Prostate Trouble	____	____
Bleeding or Clotting Disorder	____	____	Rheumatoid Arthritis	____	____	**Females:**		
High /Low Blood Pressure	____	____	Other Autoimmune Disease	____	____	Are you pregnant?	____	____
Stroke	____	____	Skin Diseases	____	____	Post-menopause?	____	____
Tuberculosis	____	____	Glaucoma/eye problems	____	____	Hormone Replacement		
Shortness of Breath	____	____	Osteoarthritis	____	____	Therapy?	____	____
Persistent Cough	____	____	Osteoporosis	____	____	Other conditions not listed: _____		
Asthma	____	____	Osteopenia	____	____	_____		
Seasonal Allergies	____	____	Have you ever taken			_____		
Emphysema/COPD	____	____	bone-sparing drugs?	____	____	_____		
Sleep Apnea	____	____	Prosthetic joints/valves	____	____	_____		
Do you snore?	____	____	Serious head/neck injury	____	____	_____		
Ear, nose, throat problems	____	____	Epilepsy/Seizures	____	____	_____		
Type I Diabetes	____	____	Fainting/Dizziness	____	____			
Type II Diabetes	____	____	Frequent Headaches	____	____			
Other Endocrine disease	____	____	Emotional Stress	____	____			
Thyroid Disease	____	____	Depression	____	____			
Hepatitis	____	____	Psycho Therapy	____	____			
Liver Disease	____	____	Other mental illness	____	____			

Signature _____ Date _____