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Patient Registration

Patient Name: _____
Last Name First Name Middle Initial Preferred Name

Address: _____
Street Address City State Zip Code

Work# _____ Home# _____ Other# _____

Sex: ___M___F Birth Date: ____/____/____ Social Security: ____/____/____ Employer: _____

Employer Address: _____

In case of an emergency, who should be notified? _____
Name and Phone Number

Whom may we thank for referring you? _____

Dental History

What is the reason for this visit? _____

Are you having any dental pain? _____ When was your last dental exam and cleaning _____

Do you have any dental concerns or questions at this time?

Have you ever been treated for periodontal disease? _____ Have you ever been treated for TMJ? _____
Have you had your 3rd molars (wisdom teeth) extracted? _____ Have you had other teeth extracted? _____

If answered "yes," why? _____

Medical History

Physician's name and phone # _____

Have you ever had the following? (Check ALL categories that apply.)

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Special Diet | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Swollen neck glands | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hepatitis, Jaundice | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Radiation Problems | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Artificial Heart valve |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Allergy to Anesthetics | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Allergy to Medicine | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Back Problems | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Immunosuppressive Disorder | | <input type="checkbox"/> Diabetes | | |

Do you have any allergies or adverse reactions to any medications? _____

Do you have to pre-medicate for any dental procedures? ___ Why? _____ Are you currently taking any Medication? _____

Are you currently under the care of a physician? ___ Why? _____ Do you suspect that you are pregnant? _____

Are you nursing? ___ Is there anything else we should know about your medical history? _____

This information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist and/or any staff member responsible for any errors or omissions that may have been made in completion of this form. I consent to all necessary dental diagnostic procedures, including, but not limited to, x-rays, examinations, photographs and diagnostic tests.

Signature: _____ Date: ____/____/____