Ginger Webb Chasolen, D.D.S., P.L.

Dr. Ginger Chasolen *Prosthodontics*
Dr. Logan Webb *General Dentistry*
1215 South East Ave. Suite 202
Sarasota, Florida 34239
(941)955-8887

Patient Registration

Patient Information

Name: _____ **Dr. Mr. Mrs. Ms.**
First Name Preferred Name Middle Initial Last Name

Residence: _____
Street Address City State Zip

Phone #: ( ) ( ) ( )
Home Cell Work

2nd Residence: _____
Street Address City State Zip

Sex: M F **Marital Status:** _____ **Height:** _____ **Weight:** _____

Social Security #: _____ **Date of Birth:** _____ **Age:** _____ **Employer:** _____

Drivers License #: _____ **Referred by:** _____

In Case of Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Primary Doctor: _____ **Pharmacy Info:** _____

Employment Status: Full Time Part Time Student Retired

Employer/School Name: _____

Insurance Information

Primary Dental Insurance	**Secondary Dental Insurance**
Policy Holders Name and SSN (if not self)	Policy *Holders* Name and SSN (if not self)
Relationship *Date* of Birth	*Relationship* *Date* of Birth
Employer:	**Employer:**
Insurance Co.:	**Insurance Co.:**
Policy/Group #:	**Policy/Group #:**

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Medical Information

Medical History

Name: _____
First Middle Initial Last

Date of Birth: _____ Height: _____ Weight: _____ Sex: M F

1. Are you currently under the care of a physician? _____ Y N
Name Reason

2. Have you been hospitalized in the past 2 years? _____ Y N
Hospital Reason

3. Are you pregnant/nursing? (if you become pregnant in the future, please be sure to inform us) Y N

4. Have you ever had a joint replacement? _____ Y N Y N
Joint Month/Year Pre-Med?

5. Have you ever had any type of heart surgery? _____ Y N
Surgery Month/Year

6. Do you have Diabetes Mellitus? Type 1 or 2 _____ Y N
Last Reported HbA1C Date

7. Do you drink alcohol, smoke or use tobacco products of any kind? _____ /day Y N

8. Have you ever taken Fosamax, Boniva, Actonel or any medications containing Bisphosphonates? Y N
Name of Medication Year taken Dose and Length of Time

9. Have you ever had Radiation or Chemotherapy Treatments? _____ Y N
Treatment Type Month/Year

10. Have you ever been instructed to take medications prior to dental treatment? Y N

11. Please list ALL medications, vitamins, and supplements you currently take. _____

_____

_____

_____

12. Do you have any allergies to the following? (if yes, please circle) Y N

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Other

Please Explain: _____

13. Do you use controlled substances or illicit drugs? _____ Y N
Drug/Substance

Medical History Continued…

14. Do you have any Heart Problems? (Ex. High Blood Pressure, History of Heart Attack, Heart Valve Replacements, Pacemaker, etc.) If yes, list below. _____ Y N

15. Do you have any Joint or Nerve Problems? (Ex. Arthritis, Alzheimer's Disease, Seizures, etc.) If yes, list below. Y N

16. Do you have any Breathing Problems? (Ex. Asthma, Emphysema, Sleep Apnea, etc.) If yes, list below. _____ Y N

17. Do you have any Blood Problems? (Ex. Anemia, Hemophilia, Bleeding/Clotting Disorders, etc.) If yes, list below. Y N

18. Do you have any Stress, Anxiety, and/or other Psychological Problems? (Ex. Bipolar, ADHD, etc.) If yes, list below. Y N

19. Do you have any Endocrine Problems? (Ex. Diabetes, Thyroid Problems, etc.) If yes, list below. _____ Y N

20. Do you have any Infection Problems/Cancer/Autoimmune Conditions? (Ex. AIDS/HIV, Hepatitis, STD's, Addison's Disease, Graves Disease, Systemic Lupus Erythematosus, etc.) If yes, list below. Y N

21. Do you have any other medical problems that you do not feel fit the areas above? (Ex. Kidney Problems, Ulcers, Liver Problems, Transplants, GERD, etc.) If yes, please list all conditions not mentioned above. _____ Y N

Other Comments: _____

Dental History

1. What is your Primary Concern? _____

2. How do you feel about your smile? _____

3. Previous and/Mutual Dentist: _____
Name City State Phone

4. Date of: _____
Last Exam Last "X-Rays" Last Cleaning

5. Do you have dental implants? _____
How Many? Where At? Placed By? When?

6. Do you have a Removable Appliance such as a denture, night guard, etc. (If so, please explain)

7. Do you have braces or any other orthodontic appliances? _____

8. Do you have sores, ulcers or any other conditions in your mouth? _____

9. Circle what applies to your teeth/mouth
Cracked/Fractured Sensitivity Pain Soreness Staining Bleeding Gums
Please Explain: _____

10. Circle what applies to your oral hygiene

Brush 1x or 2x Daily	Floss Daily	Use Fluoride Toothpaste	Use Prescription Toothpaste	Use Mouthwash Daily
Drink City Water	Drink Well Water	Diet High in Sugar	Other:	

11. Are you aware of/suspect any problems to your head, mouth, jaw, TMJ, or teeth? (if so, please explain)

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____