Adult Registration Form

Date______Patient ____

First Name   Middle Initial   Last Name   Preferred Name

Street Address____

City, State, Zip Code ____

Preferred Contact Method ☐ Home ☐ Cell ☐ Email

Home________________Work________________Cell________________

Email Address____

Married____________Single____________Minor____________Male________Female________

Birth Date____

Social Security Number____

Employer____________________________ Occupation____________________________

Employer Address____

Spouse Name____________________________ Spouse Birth Date____________________________

Spouse Employer____________________________ Occupation____________________________

Dental Insurance Information (if applicable):

☐ Medicaid ☐ Medicare

Insured ____________________________ Employer ____________________________

Name of dental insurance company ____

Dental insurance company claim address____

Group number for policy____

Social Security number or i.d. of policyholder____

Birth date of policyholder____

Emergency contact and phone number ____

Who may we thank for referring you? ____

Authorization: I understand that I am responsible for all costs of dental treatment. I hereby authorize High Desert Dental, Joshua M. Eastham, DMD to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical history are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical history and other information about my dental treatment to third party payers and/or other health professionals by any method, including electronic transfer.

Patient or Parent____

HIGH DESERT
DENTAL
Joshua Eastham, DMD

High Desert Dental – Joshua M. Eastham, DMD
132 Walnut Avenue, Ste. F, Grand Junction, CO 81501 (970) 245-1758

Patient Name: ________________________________ **Date:** ____________

Primary reason for this dental appointment: ___Examination ___Emergency ___Consultation

Dental History **Please Circle**

Do you have a specific dental problem? Describe ______________________________ Yes No

Do you have dental examinations on a routine basis? Date of last visit ____________________ Yes No

Do you think you have active decay or gum disease? ______________________________ Yes No

Do you brush and floss on a routine basis? ______________________________ Yes No

Do you like your smile? ______________________________ Yes No

Does food catch between your teeth? ______________________________ Yes No

Do you have any loose teeth? ______________________________ Yes No

Do you want to keep your remaining teeth? ______________________________ Yes No

Do you ever have clicking, popping, or discomfort in the jaw joint? ____________________ Yes No

Do you grind your teeth? ______________________________ Yes No

Do you smoke or chew? ______________________________ Yes No

Do you have any sores or growths in your mouth? Describe ____________________ Yes No

Medical History

Are you under a physician's care now? If yes, why? ______________________________ Yes No

Who is the physician? ______________________ Phone # ______________

Have you ever been hospitalized or had a major operation? Describe ____________________ Yes No

Have you ever had a serious injury to your head or neck? Describe ____________________ Yes No

Are you on a special diet? Describe ______________________________ Yes No

Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? List ______________ Yes No

(attach a list if you need more space) ______________________________

Are you taking blood thinners? ______________________________ Yes No

Are you allergic to any medications or substances? If yes, please check item below:

____Aspirin ____Penicillin ____Codeine ____Acrylic ____Metal ____Milk ____Other

Women: (please check) ___Pregnant/trying to get pregnant ____Nursing ____Taking oral contraceptives

Do you now or have ever had any of the following? Please check all that apply. If you answer "yes" to any of the conditions, please call prior to your appointment as premedication or changes in medication may be required.

Medical Condition	Yes	No	Medical Condition	Yes	No	Medical Condition	Yes	No
AIDS			Fainting /Dizziness			Osteoporosis		
Medicine Allergies			Frequent Cough			Pain in Jaw Joints		
Pollen/Dust Allergies			Frequent Diarrhea			Parathyroid Disease		
Alzheimer's Disease			Genital Herpes			Protease Inhibitor		
Anemia			Glaucoma			Psychiatric care		
Angina/Chest Pain			Hay Fever			Pulmonary Shunt		
Aredia I.V. Reclast I.V.			Heart Attack			Recent Blood Transfusion		
Artificial Heart Valve			Heart Disease/ Surgery			Recent Weight Loss		
Artificial joint			Heart Murmur or Defect			Renal Dialysis		
Asthma			Heart Pace Maker			Rheumatic Fever		
Arthritis/Gout			Hemophilia			Rheumatism		
Bacterial Endocarditis			Hepatitis A			Scarlet Fever		
Bisphosphonates			Hepatitis B or C			Shortness of Breath		
Bloody Sputum			Herpes			Sexually Transmitted Disease		
Breathing Problems			High Blood Pressure			Sickle Cell Disease		
Bruise Easily/ Blood Disease			HIV Positive			Sinus Trouble		
Cancer			Hives or Rash			Sleep Apnea		
Chemotherapy			Hypoglycemia			Stomach/Intestinal Disease		
Cold Sores			Irregular Heart Beat			Stroke		
Cochlear Implants			Kidney Problems			Swelling of Limbs		
Congenital Heart Disorder			Leukemia			Tattoos/Body Piercing		
Coronary Stent			Liver Disease			Thyroid Disease		
Cortisone Medicine			Low Blood Pressure			Tuberculosis		
Diabetes			Lung Disease			Tumors or Growths		
Drug Addiction/Alcoholism			Methemoglobinemia			Ulcers		
Emphysema			Mitral Valve Prolapse			Unexplained Fever		
Epilepsy or Seizures			Need Premedication			Radiation Treatment		
Excessive Bleeding			Nervousness			Yellow Jaundice		
Excessive Thirst			Night Sweats			Zometa IV		
Fosamax, Actonel, Boniva			Osteonecrosis of Jaw					

Have you ever had any other serious Illness not checked above? Describe ________________ Yes No

Do you wish to talk to the dentist Privately about any problem? ________________________ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicine changes, I shall inform the dentist and staff at the next appointment without fail.

X____ **Date: ________________________**

Patient Signature (parent or guardian)

Reviewed by Doctor________________________________ **Date: ________________________**

History Review and Significant Findings____

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Medical Updates:

I have read my MEDICAL HISTORY dated ________________ and confirm that it adequately states past and present conditions.

Date	Exceptions	No Change	Patient's Signature	Reviewed by:
				Dr.
				Dr.
				Dr.
				Dr.
				Dr.
				Dr.