7509 Draper Ave.
La Jolla, CA 92037
858 454-8484

PATIENT REGISTRATION

PATIENT INFORMATION

Name____ Date of Birth:_____________ Age: ________ Gender: _______Date:_________
Address:___________________________________ City:__________________ State:______ ZIP:________ Home phone:________________
Occupation:_________________________ SSN:_________________ Email:_________________________Cell phone:__________________
Employer: __________________________ Address: ______________________________ Pharmacy: _______________________________

Primary physician:____ Phone:____________________________
Specialist physician:____ Phone:____________________________

Medical insurance:_______________________ Group:____________________ Member ID:_____________________ Active date: _________
Primary Dental Insurance:_________________ Group:____________________ Member ID: _____________________Active date: _________
Subscriber: ____ Date of Birth: ______________________________________
Secondary Dental Insurance:_______________ Group:____________________ Member ID: _____________________Active date: _________

GUARDIAN INFORMATION

Name____ Date of Birth:___________ Age: ________ Gender: _______Date:_________
Address:___________________________________ City:__________________ State:______ ZIP:________ Home phone:________________
Occupation:_________________________ SSN:_________________ Email:_________________________Cell phone:__________________

EMERGENCY CONTACT INFORMATION

Name____ Date of Birth:______________________________
Address:____ City:______________________ State:__________ ZIP:_______________
Home phone number:________________________ Cell number:_________________________ Email:_______________________________

AKNOWLEDGEMENT

I certify that I (or my dependent) have insurance coverage with ____ and assign directly to Dr. Osmolinski (La Jolla Family Dentistry) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

***Responsibly party signature*___________________________________ *Relationship*_______________________ *Date*________________**

DENTAL HISTORY

Reason for today's visit: ____ Who may we thank for referring you: ________________________
Former dentist:____ City:______________________________ State:_______________
Date of the last dental visit:__________________________ Reason:____
Please elaborate on any past unpleasant experience in a dental office:____

Do you suffer from any of the following:

bad breath	Y	N	sensitivity to cold	Y	N
blisters on lips or mouth	Y	N	sensitivity to hot	Y	N
sores or growths in mouth	Y	N	bleeding gums	Y	N
mouth breathing	Y	N	swollen or tender gums	Y	N
clicking or popping of the jaw	Y	N	cigarette, pipe, cigar smoking	Y	N
missing teeth	Y	N	chewing tobacco	Y	N
pain around the ear	Y	N	dry mouth	Y	N
sensitivity when biting down	Y	N	food collection between teeth	Y	N
grinding or clenching teeth	Y	N	sensitivity to sweet	Y	N
loose teeth or broken fillings	Y	N	burning sensation on the tongue	Y	N
pain with brushing	Y	N	lip or cheek biting	Y	N

Have you ever had:

periodontal therapy	Y	N	oral surgery	Y	N
orthodontic therapy	Y	N	dental treatment under anesthesia	Y	N

GENERAL MEDICAL HISTORY

Are you in good health? Y N
Any change in your health within past 1 year? Y N
Date of the last physical examination ______________
What is your weight ______________
What is your height ______________
Have you been seriously ill in the past 5 years? Y N
Did you undergo any surgery in the past 5 years Y N
Have you been hospitalized in the past 5 years? Y N

MEDICATIONS - SUPPLEMENTS - HERBAL REMEDIES

____
____
____
____
____

ALLERGIES

____
____
____
____
____

CARDIOVASCULAR SYSTEM

congenital heart defects Y N
damaged/ artificial heart valves Y N
rheumatic heart disease Y N
history of heart attack Y N
angina, coronary insufficiency Y N
blood pressure abnormalities Y N
arteriosclerosis Y N
high cholesterol Y N
history of stroke Y N
chest pain upon exertion Y N
short of breath after exercise Y N
swollen ankles Y N
cardiac pacemaker Y N

RESPIRATORY SYSTEM

difficulty breathing or sinus trouble Y N
asthma or hay fever Y N
respiratory problems or emphysema Y N
history of tuberculosis Y N
persistent cough or cough with blood Y N
obstructive sleep apnea Y N
pulmonary embolism Y N
swollen lymph glands Y N
recent respiratory infection Y N

HEPATO-GASTRO-INTESTINAL SYSTEM

diabetes Y N
hepatitis or liver diseases Y N
weight loss/ eating disorder Y N
episodes of nausea or vomiting Y N
stomach ulcer or hyperacidity Y N
reflux disease/ gag reflex Y N
pancreatitis/ gallbladder disease Y N
diarrhea/ bowel obstruction Y N
Crohn's disease/ Irritable Bowel Syndrome Y N
hiatal hernia Y N

NEURO-MUSCULOSKELETAL SYSTEM

recurrent headaches/ migraines Y N
fainting/ seizures/ epilepsy Y N
emotional/ mental health problems Y N
serious head injury/ trauma Y N
paresthesia/ stroke Y N
developmentally delayed Y N
psychiatric disorder Y N
cerebral palsy/ paralysis Y N
multiple sclerosis Y N
osteoporosis/ osteopenia Y N
problems with cervical spine Y N
arthritis/ painful swollen joints Y N
degenerative joint disease Y N
artificial joints/ joint replacement Y N
back problems Y N

RENAL-ENDOCRINE SYSTEM

thyroid problems Y N
kidney problems/ dialysis Y N
adreno-cortical insufficiency Y N
pituitary disorder Y N
steroid use Y N
hormonal disturbances Y N

OTHER SYSTEMS

anemia Y N
abnormal bleeding Y N
history of blood transfusions Y N
cancer/ history of tumor growth Y N
problems with auto-immune system Y N
eye disease/ glaucoma/ contact lenses Y N
hoarseness Y N
hearing impairment Y N
sexually transmitted disease Y N
HIV infection/ AIDS Y N
any disease not listed above Y N

SOCIAL HISTORY

smoking or chewing tobacco Y N
alcohol Y N
illicit/ street drugs Y N
any disability Y N
history of treatment with BIPHOSPHONATES Y N

how much _________________ ppd _________________ years
how much _________________ drinks ________________ week
specify ____
immunization up to date Y N
have you ever taken Phen-Fen or Reduxa Y N

WOMEN

Are you **pregnant** or trying to get pregnant Y N
Any problems with the menstruation periods Y N

If pregnant, how many weeks ____________________________________
Are you nursing Y N

CHILDREN

Were there any complications during the pregnancy? Y N
Your child was born at: _______________________________ weeks
Complications during the newborn period:____

How was your child delivered VAGINAL C-SECTION
If C-SECTION, reason:__________________________________

ANESTHESIA HISTORY

Have you ever had administered any type of anesthesia? Y N
Specify ____________________

Have you ever had any **complications with anesthesia**? Y N
Specify ____________________

Had anybody from your family have any problems with anesthesia? Y N
Specify ____________________

Do you have a family history of malignant hyperthermia? Y N
Do you have history of prolonged nausea and vomiting after anesthesia? Y N
Do you have a history of difficult airway? Y N
Do you have problems with your temporomandibular joint? Y N
Do you have limited mouth opening? Y N
Did you ever had any operation or radiation in your maxillofacial region? Y N
Did you undergo any ENT procedures before? Y N
Have you ever had tracheostomy procedure done? Y N
Do you have a history of difficult IV start? Y N
Have you ever had any abnormal reaction to medications? Y N

I certify that I have provided an accurate and complete personal and medical history and I have not knowingly omitted any information. I understand that providing incomplete or inaccurate information may negatively influence the treatment and treatment results. Should there be any change in either my health status or any other information I have provided, I will advise my dental anesthesiologist. I authorize Dr. Osmolinski and Associates to request to have diagnostic procedures performed as may be required to determine the necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy.

Patient name ____________________ Patient signature ____________________ Date __________

Doctor name ____________________ Doctor signature ____________________ Date __________

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
R				A	B	C	D	E	F	G	H	I	J				L
				T	S	R	Q	P	O	N	M	L	K				

Tooth	Clinical Findings	Radiographic Findings	Treatment Options	Seq.	Time