For Office Use Only

Patient Registration

Please complete all 3 pages of this form in its entirety and legibly. We will need be in contact with you regarding your appointment time on October 19th. Please note that due to some patient's health history and conditions, the treating dentist may need to confer with your primary care physician or other doctors who care for you, prior to the treatment day. A thorough list of doctors and medication are necessary to ensure that all participants in our Freedom Day USA event are provided proper health care, including any necessary pre-medications or consultations.

Full Name: _____

Preferred to be called: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Date of Birth: _____ Gender: _____

Please circle if you have had any of the following problems:

Food collecting between teeth Loose teeth

Sores/Growths in Mouth Periodontal Disease/Treatment

Sleep Apnea Diagnosis Prescribed a CPAP

Sensitivity to: Cold Heat Sweets When Biting

What is your reason/chief complaint for visiting us today?

_____

Do you have any teeth or areas of your mouth that are causing you discomfort or concern? Please explain:

_____

_____

ARE YOU CURRENTLY USING ANY OF THE FOLLOWING:

Antibiotics?	Y	N
Anticoagulants? (Blood Thinners) Last INR? _____	Y	N
Aspirin or drugs such as Motrin, Aleve, ibuprofen?	Y	N
High blood pressure medication?	Y	N
Steroids? (cortisone, prednisone, etc.)	Y	N
Tranquilizers?	Y	N
Insulin or oral anti-diabetic drugs?	Y	N
Digitalis, Inderal, nitroglycerin or other heart drug?	Y	N
Bisphosphonates? (Bone Medicines,Fosamax, Zometa, etc.)	Y	N
Medicinal or Recreational Marijuana?	Y	N
Herbal or holistic remedies?	Y	N
Vitamins?	Y	N
Over-the-counter medications?	Y	N

Please list <u>ALL MEDICATIONS</u> including prescriptions, herbal, vitamins, and over-the-counter, and the dosages, or attach a medication list.

_____

_____

_____

_____

Pharmacy: _____

Phone Number: _____

All information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I hereby agree and give my consent for Freedom Day Dental Professionals to provide necessary x-rays, limited dental exams, hygiene cleanings, root canals, necessary extractions, and fillings. I understand that there are several treating doctors who will decide what is my most pressing dental need after reviewing these forms and my x-rays. I understand that I may need more dental treatment than what I will receive from volunteers on October 19th. I understand that services rendered on September 10 and October 19 will be free of charge, but additional treatment, should I agree to it on another date, will be provided at the treating doctors regular fee schedule.

X _____ _____

Signature of Participant Today's Date

Health History

PATIENT'S NAME: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

Date of last physical exam: _____

Has there been any change in your general health in the past year? ..... Y N

If yes, what? _____

Are you under a physician's care for a particular problem? ... Y N

If so, please describe: _____

_____

Have you ever had any serious illnesses, operations, or hospitalizations? ..... Y N

If so, please describe: _____

_____

Please provide your primary care physician's name and phone number as well as any other doctor that you are currently seeing for medical care or advice:

Primary Care Doctor: _____

Phone: _____

Doctor & Specialty: _____

Phone: _____

Doctor & Specialty: _____

Phone: _____

FEMALE PATIENTS ONLY

Are you pregnant or is there any chance you might be pregnant? ..... Y N

Are you nursing? ..... Y N

***** If you are using oral contraceptives it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Extra birth control methods should be taken. *****

ALERGIES...Please mark all that apply

- ☐ Latex
- ☐ Erythromycin
- ☐ Aspirin
- ☐ Hydrocodone
- ☐ Local Anesthesia (Novocain, etc.)
- ☐ Sulfa
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Soy/Eggs/Peanuts
- ☐ Other: List _____

HAVE YOU EVER HAD:

Rheumatic fever or rheumatic heart disease? ..... Y N

Congenital heart disease (birth defect)? ..... Y N

Heart Murmur or Mitral Valve Prolapse (MVP)? ..... Y N

Cardiovascular disease — **if yes circle below** ..... Y N

heart attack heart trouble coronary arterary disease heart surgery angina high blood pressure stroke

Palpitations, atrial fibrillation, arrhythmia, irregular heartbeat? ... Y N

Lung disease — **if yes circle below** ..... Y N

Asthma Emphysema Chronic cough Tuberculosis Shortness of Breath Chestpain

Seizures, convulsions, Epilepsy, fainting, dizziness? ..... Y N

Psychiatric treatment or other nervous disorder? ..... Y N

Bleeding disorder, bleeding tendency, blood transfusion? .... Y N

Liver disease? (Hepatitis) ..... Y N

Kidney disease? (renal failure) ..... Y N

Diabetes? ..... Y N

Thyroid disease? (goiter) ..... Y N

Arthritis? ..... Y N

Stomach ulcers, Gastritis, Reflux or Colitis? ..... Y N

Glaucoma? ..... Y N

Implants placed anywhere in your body — **if yes circle below** .... Y N

heartvalve pacemaker hip knee tooth

Cancer — **if yes list types below** ..... Y N

_____

Radiation (x-ray) or Chemotherapy treatment for cancer? ... Y N

Clicking or popping of jaw joint, pain near ear, difficulty opening mouth? ..... Y N

Sinus or nasal problems? ..... Y N

Any disease, drug, or transplant operation that has depressed your immune system? ..... Y N

HIV, AIDS, or ARC? ..... Y N

Have you ever smoked or chewed tobacco or marijuana? .... Y N

How much per day? _____ Years: _____

Do you drink alcohol? ..... Y N

How much per week? _____

Is there any past history of alcohol or chemical dependency or emotional disorder? ..... Y N

Have you or an immediate family member had any problem associated with intravenous anesthesia? .... Y N

Do you have any other disease, condition, or problem not listed that the doctor should know about? ..... Y N

_____

_____

Patient Survey & Releases

PATIENT'S NAME: _____ PHONE: _____

Please read and initial the following statements:

_____ I authorize release of medical and dental information and other information as is necessary for treatment and health care operations during the Freedom Day USA event

_____ I authorize Freedom Day USA volunteers to contact my physicians with any questions regarding my health and necessary dental treatment.

_____ I authorize the following people to have access to my treatment plan, pre-procedure and post-procedure instructions and care.

_____ _____ _____

_____ The following person(s) are NOT authorized to have any access to my treatment plan or my healthcare and dental information.

_____ _____ _____

PHOTOGRAPHY AND STATEMENT RELEASE

It is common for both a photographer and videographer to attend our Freedom Day USA event. Also, many patients decide to leave us a testimonial for the services they are provided on that day. The following statement with your signature allows us to share your Freedom Day USA experience with people not only in Weld County, but also the national event.

I, _____, hereby authorize all offices participating in the 2018 Freedom Day USA event in Greeley, CO, to utilize photos, video, testimonials, and other printed materials featuring my name (First name, last initial), likeness, and photograph.

I understand that the photographs, information, and/or videos can be used as a record of my care or record of service received, may be used for educational purposes in lectures, demonstrations, or event and business advertising, including website, publication, newspapers, magazines, phone books, televisions, and in professional publications such as dental magazines and journals.

I do not expect compensation, financial or otherwise, for the use of these photographs, videos, or testimonials.

Printed Name: _____ Signature: _____ Date: _____

As previously stated, we will not be able to treat all your dental needs at our event. We will be taking x-rays and reviewing your health history, but to help us in our process please complete the following questions:

What service do you feel you need most:

- ☐ Dental Cleaning
- ☐ Dental Fillings
- ☐ Extractions
- ☐ Root Canal

Please use this space to tell us about your dental needs, concerns, past dental issues, or any other dental related information you think might be helpful for us regarding your treatment:

_____

_____

_____

_____