EXCELLENCE IN CARE,
SKILL AND JUDGEMENT

Deepa Suryanarayanan DMD

GENERAL, COSMETIC, AND ORTHODONTIC DENTISTRY

Patient Registration Form

Date _____

Last name_____
First name _____
Home Address_____
City, State, Zip
_____
Home phone ( )_____ Cell phone ( )_____
Email address: _____
Social Security: _____Birth Date:_____
Employed by_____Work phone ( ) _____
Employer's Address_____
Position_____
Name of Parent or Spouse _____
Parent or Spouse Employed by_____Business Phone ( ) _____
Whom may we thank for referring you to our office? Name_____
Why did you choose Dr Deepa as your dentist? _____
Has any member of your family been treated in our office?_____
Person Responsible for payment _____
Reason for your visit _____

Gums

1. Are the gums pink and "knife-edged" (versus red and swollen)? Y _____ N ____
2. Have the gums receded from the necks of the teeth Y _____ N _____
3. Is there bleeding when you brush or use a pick? Y _____ N _____
4. Is there severe sensitivity anytime? Y _____ N _____

Breath

1. Is your breath sometimes unpleasant? Y____ N_____
2. Why? _____
3. Is your mouth free from decay or gum disease that causes bad breath Y _____ N _____

6525 BELCREST ROAD SUITE 212 - HYATTSVILLE, MARYLAND 20782 301-927-2900
4701 RANDOLPH ROAD SUITE 114 - ROCKVILLE, MARYLAND 20877 301-770-5353

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MEDICAL HISTORY

This information must be completed for all patients. Any information contained will not be released without the patient's or legal guardian's written authorization.

Name of Previous Dentist _____Phone_____
Address_____
Name of Patient's Physician_____ Phone_____
Address _____
Date of Last Physical Examination _____

1. Have you been a patient in a hospital in the last 5 years? Y___ N___
2. Are you know or have you been under the care of a doctor during the past year? Y___ N____
3. Have you ever had a serious illness or major surgery? Y____ N_____
4. Have you ever had an allergic reaction to any drug, medication, or anesthetic? Y____N___
   If Yes, the name _____
5. Do you know have any signs of a cold, sinus, postnasal drainage allergy or cough? Y____N____
6. Have any wounds healed slowly or presented complications? Y____ N____
7. Have you ever had any excess bleeding requiring special treatment? Y____N____
8. Have you had a blood transfusion in the past 5 years? Y____N____
9. Name any medications you are taking _____
10. Name any medications you have taken during the past year (if different)_____
    _____
11. Are you pregnant? Y____N____
12. Are you taking birth control pills? Y____N____
13. Do you need to take (as instructed by a physician) an antibiotic before dental treatment? Y____N____
14. Do you have or have you ever had any of the following (please check all that apply):

( ) Jaws Lock	( ) Tuberculosis	( ) Clenching
( ) Heart Trouble	( ) Heart Surgery	( ) Epilepsy
( ) Congenital Heart Defect	( ) Kidney Disorders	( ) Fainting Spell
( ) Heart Murmur	( ) Jaundice	( ) Thyroid Disease
( ) High Blood Pressure	( ) Tumors, Growths	( ) Sickle cell Anemia
( ) Rheumatic Fever	( ) Shortness of Breath	( ) Cortizone Therapy
( ) Anemia	( ) Bronchitis	( ) Radiation Therapy
( ) Bleeding Problems	( ) Liver Disease	( ) Stomach Disorder
( ) Stroke	( ) Hepatitis	( ) Intestine Disorder
( ) Asthma	( ) Arthritis	( ) Headaches
( ) Lung Disease	( ) Diabetes	( ) Eating Disorders
( ) Ear-Check Clicking	( ) Ulcers	( ) AIDS

15. Have you been tested for the AIDS virus? If yes, results:_____
16. Do you smoke? Y_____N_____ If yes, packs per day _____
17. Is there any additional information about your health that should be known? _____
_____

This form is certified to be accurate and complete to the best of my knowledge.

Signature _____ Date_____

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