Lakeside Endodontics
Shahin Etemadi DDS, MSD
10025– 19th Ave SE, Ste. 202
Everett, WA 98208

MEDICAL REGISTRATION FORM

General Dentist: _____ Today's Date: _____

Name: _____ Birthdate: _____ Soc.Sec. #: ____-_____-____

Address: _____ Unit/Apt.#: _____

City: _____ State: _____ Zip:_____ Email :_____@_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Check Appropriate Box: □ Minor ☐ □ Single ☐ □ Married ☐ □ Divorced ☐ Widowed ☐

Employer: _____ Occupation: _____ Work Phone: (___) _____

Work Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse Employed By: _____ Bus. Phone: (___) _____

Emergency Contact: _____ Relationship: _____ Phone: (___)_____

Person Responsible for this account: □ Self ☐ □ Other: Name/Relationship: _____

Medical History

Physician: _____ Office Phone: (___)_____ Date of last visit: _____

- ❖ Are you currently under medical care or treatment? □ Yes ☐ □ No ☐
- ❖ Have you been hospitalized for any surgical operation or serious illness in the past six months? □ Yes ☐ □ No ☐
- ❖ Are you currently taking or have you ever taken Osteoporosis medication? Yes ☐ No ☐
- ❖ Do you need to be premedicated for heart murmur or joint replacement? □ Yes ☐ □ No ☐
- ❖ Do you drink grapefruit juice? □ Yes ☐ □ No ☐
- ❖ Are you taking any medication(s) including non-prescription? □ Yes ☐ □ No ☐
  If yes, what are you taking? _____
- ❖ Are you allergic to any medication(s)? □ Yes ☐ □ No ☐
  If yes, what? _____
- ❖ Are you allergic to Latex? Yes ☐ No ☐
- ❖ Do you smoke? □ Yes ☐ □ No ☐ How many per day? _____
- ❖ Do you use alcohol? □ Yes ☐ □ No ☐ How many per day/week? _____
- ❖ Have you used any narcotics or recreational drugs in the last 48 hours? Yes: What? _____ No ☐

Women Only

Are you pregnant? □ Yes ☐ □ No ☐

- ❖ Is there any chance you may be pregnant? ☐ Yes ☐ ☐ No ☐
- ❖ Are you trying to get pregnant? ☐ Yes ☐ ☐ No ☐
- ❖ Are you taking birth control? ☐ Yes ☐ ☐ No ☐
- ❖ Are you nursing? ☐ Yes ☐ No ☐

- Do you have or have you had any of the following:

Yes ☐ No ☐ High Blood Pressure
Yes ☐ No ☐ Low Blood Pressure
Yes ☐ No ☐ Heart Attack
Yes ☐ No ☐ Rheumatic Fever
Yes ☐ No ☐ Thyroid Problem
Yes ☐ No ☐ Fainting
Yes ☐ No ☐ Seizures
Yes ☐ No ☐ Asthma
Yes ☐ No ☐ Epilepsy/Convulsions
Yes ☐ No ☐ Leukemia
Yes ☐ No ☐ Diabetes, Type: _____
Yes ☐ No ☐ Kidney Disease
Yes ☐ No ☐ Stroke
Yes ☐ No ☐ Tuberculosis
Yes ☐ No ☐ Chemotherapy
Yes ☐ No ☐ Unexpected Weight Loss
Yes ☐ No ☐ Psychiatric Treatment
Yes ☐ No ☐ Heart Disease

Yes ☐ No ☐ Cardiac Pacemaker
Yes ☐ No ☐ Heart Murmur (MVP)
Yes ☐ No ☐ Angina (Chest Pain)
Yes ☐ No ☐ Frequently Tired
Yes ☐ No ☐ Anemia
Yes ☐ No ☐ Emphysema
Yes ☐ No ☐ Cancer
Yes ☐ No ☐ Arthritis
Yes ☐ No ☐ Joint Replacement
Yes ☐ No ☐ Hepatitis/Jaundice
Yes ☐ No ☐ Sexually Transmitted Disease
Yes ☐ No ☐ Stomach Ulcers
Yes ☐ No ☐ Hay Fever/Allergies
Yes ☐ No ☐ Radiation Therapy
Yes ☐ No ☐ Glaucoma
Yes ☐ No ☐ Liver Disease
Yes ☐ No ☐ AIDS or HIV Infections
Yes ☐ No ☐ Other: Please specify
_____

- Do your gums bleed when brushing or flossing? Yes ☐ No ☐
- Are your teeth sensitive to hot or cold liquids/foods? Yes ☐ No ☐
- Are your teeth sensitive to sweet or sour liquids/foods? Yes ☐ No ☐
- Do you feel pain to any of your teeth? Yes ☐ No ☐
- Do you clinch or grind your teeth? Yes ☐ No ☐
- Have you experienced prolonged bleeding following an extraction? Yes ☐ No ☐
- Have you ever had periodontal treatment or gum treatment before? Yes ☐ No ☐
- When was your last routine dental cleaning? Date: _____
- How often do you brush your teeth? _____per day
- Do you feel nervous about having dental treatment? Yes ☐ No ☐

AUTHORIZATION AND RELEASE

I certify that I have read and understand that above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payors and/or health practitioners. I understand that my dental insurance carrier may pay less than the dental bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent.

_____ _____

Signature of patient or parent if minor Date

Comments: _____

_____

_____

Signature of Doctor Date