John A. Carollo, DMD
General & Family Dentistry
131 Columbia Turnpike, Suite 2A
Florham Park, NJ 07932 (973) 377- 5117

Adult Registration & Health History

Name_____ Marital Status: S M W D
Last First Middle

Address_____City_____State_____Zip Code_____

Home Phone # _____Emergency #_____Cell # or Beeper #_____ Date of Birth_____

Employed By: _____ Occupation_____ Social Security #_____

Business Address: _____ City _____State _____ Zip Code_____

Business Phone#: _____ Fax # :_____ E-mail_____

Dental Insurance Carrier, Self_____ Group #:_____

Spouse's Name_____ Date of Birth_____

Spouse Employed By: _____ Occupation: _____ Social Security # _____

Spouse's Business Address: _____ City _____ State _____ Zip Code_____

Spouse's Business Phone# _____ Fax # _____ E-mail_____

Spouse's Dental Insurance Carrier_____ Group # _____

Referred to Dr. Carollo's office by: _____

Medical History: *Please Write Your Answers As Complete As Possible; All Information Is Confidential*

Physician's Name Address and Phone #: _____

_____

1. Are you presently under the care of a physician? _____Date of last Exam_____
   If Yes, for what condition? _____
2. Has there been any change in your general health within the past year?_____ Explain_____
3. Have you ever had a serious Illness? _____ If Yes, Please Explain_____
4. Are you presently taking any medications? _____ Please Identify and explain need:_____
   _____
5. Have you ever had a heart murmur of rheumatic fever? _____ When? _____
6. Have you ever had high blood pressure? _____ or low blood pressure? _____
7. Have you ever had Heart Disease? Angina? Heart Attack? Pacemaker? _____ When? _____
8. Have you ever had diabetes? _____ If yes, date of onset _____
9. Have you ever had any blood disorders or anemia? _____ When? _____
10. Have you ever had tuberculosis? _____ When? _____
11. Have you ever had asthma or lung disorders? _____When? _____
12. Do you smoke? _____ Number of packs per day? _____
13. Have you ever had a stroke? _____ When? _____
14. Have you ever had hepatitis or liver disease? _____Have you ever had a kidney disorder? _____
15. Do you have arthritis or other joint disorders? _____ Do you have sinus trouble or allergies? _____

16. Have you ever had a thyroid condition? _____ When? _____

17. Have you ever had fainting spells or seizures? _____ Have you ever had epilepsy? _____

18. Have you ever had glaucoma or cataracts? _____ Do you wear glasses? _____Contact lens' _____

19. Have you ever had a malignancy? _____ When? _____

20. Have you ever had radiation treatment? _____ If yes, for what? _____

21. Have you ever had abnormal bleeding associated with previous dental extractions, surgery or trauma? _____

22. Have you ever had a nervous or psychological condition? _____

23. Do you have ulcers or stomach problems? _____

24. Have you ever had venereal disease, AIDS, or immunosuppressive disorders? _____

25. Are you allergic to penicillin, sulfa, other antibiotics, codeine, aspirin or other medications? _____

26. Have you ever had a reaction or allergy to dental anesthesia, (e.g. novocaine)? _____

WOMEN: Are you pregnant? _____ Are you nursing? _____ Are you taking oral contraceptives? _____

Do you have any problems associated with your menstrual period? _____ Have you reached menopause? _____

Dental History:

1. Reason for today's visit? _____ Are you having any discomfort? _____ How long? _____

2. When was your last dental visit? _____ Were x-rays taken? _____

3. Have you ever had a problem associated with previous dental treatment? _____ Explain? _____

4. Have you been instructed in proper oral hygiene? _____ How often do you brush? _____ Floss? _____

5. What type of toothbrush are you using, (hard, medium or soft)? _____ Do you use and electric toothbrush? _____

6. Are you using other Dental Aids: Proxibrush? Rubber tip? Fluoride Rinses? _____ Do your gums bleed when you brush or floss? _____

7. Are your teeth sensitive to hot, cold or sweets? _____ Explain _____

8. Have you ever had orthodontics, (braces)? _____ When? _____

9. Have you ever had endodontics, (root can therapy)? _____ When? _____

10. Have you ever had periodontal, (gum treatment)? _____ When? _____

11. Do you clench or grind your teeth while sleeping or during the day? _____ Does your jaw ache or feel tired? _____

12. Do you snore when sleeping? _____ Do you feel tired during the day? _____

13. Does your jaw click or make noises when you chew? _____ Do you have an unpleasant taste in your mouth? _____

14. Have any missing teeth been replaced by bridgework, dentures or implants? _____ What type of replacement?_____

15. Do you have any oral habits such as chewing on pencils, pens, cheek or nail biting? _____ Explain _____

16. Have you ever had previous unpleasant experiences from dental treatment? _____ Explain_____

17. Do you want to know how to maintain your natural teeth & restoring them to proper health? _____

18. Do you want to know about new advances in dentistry, (sealants, cosmetic procedures, veneers, dental implants, etc.)? _____

I certify that the above information has been answered to the best of my ability.

Patient's signature_____ Date: _____

Medical and Dental History Updates and Changes

Date: _____ Changes: _____ Initial: _____

Date: _____ Changes: _____ Initial: _____

Date: _____ Changes: _____ Initial: _____

Date: _____ Changes: _____ Initial: _____