Please complete the following confidential patient registration form and dental history:

Responsible Party Information:

Last Name_____First Name_____Middle Initial_____

Address_____City_____State_____

Zip Code_____

Home Phone ( )_____Work( )_____Cell ( )_____

Date of Birth_____Age_____Marital Status_____

Patient (If other than Responsible Party):

Last Name_____First Name_____Middle Initial_____

Address_____City_____State_____

Zip Code_____

Home Phone ( )_____Work ( )_____Cell ( )_____

Date of Birth_____Age_____Marital Status_____

Whom May We Thank For Referring You? _____

Preferred Pharmacy _____ Phone #_____

Email Address_____

Current Physician or Medical Doctor_____

Phone # _____

Children or Family Members Currently in Our Practice:

_____

_____

Dental History

Patient Name:_____ Date:_____

- □ Yes □ No **Do your gums bleed while 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 have discomfort with your teeth?**
- □ Yes □ No **Do you have lumps in or near your mouth?**
- □ Yes □ No **Have you had any neck, head, or jaw injuries?**
- □ Yes □ No **Have you ever experienced any of these problems in your jaw?**
  □Clicking □Discomfort (joint, ear, side of face) □ Difficulty Opening or Closing
  □ Difficulty Chewing □ Bite does not feel right
- □ Yes □ No **Do you have frequent headaches?**
- □ Yes □ No **Do you clench or grind your teeth?**
- □ Yes □ No **Have you ever had a difficult extraction in the past?**
- □ Yes □ No **Have you ever had prolonged bleeding following an extraction?**
- □ Yes □ No **Have you had orthodontic treatment?**
- □ Yes □ No **Do you get cold sores or fever blisters, or herpes lesions?**
- □ Yes □ No **Do you consider yourself a nervous dental patient?**
- □ Yes □ No **Have you ever needed sedation for dental treatment?**
- □ Yes □ No **Have you ever received oral hygiene instructions regarding the care of your teeth & gums?**
- □ Yes □ No **Have you ever had periodontal (gum) treatments or deep scalings (cleanings)?**
- □ Yes □ No **Do you like your smile (color, shape, appearance of your teeth)?**
- □ Yes □ No **Do you feel that your teeth don't fit together well when you bite?**
- □ Yes □ No **Do you feel like you have bad breath often?**
- □ Yes □ No **Do you feel that your teeth have shifted or moved?**
- □ Yes □ No **Are you interested in cosmetic dentistry?**

□ Yes □ No **If you have missing teeth, would you be interested in knowing more about implant options?**

□ Yes □ No **Have you ever had a reaction to local anesthesia (Novocain)?**

FOR DENTURE AND PARTIAL WEARERS

How long have you worn dentures/partials?_____
How many sets of partials/dentures have you had throughout your life? _____

- □ Yes □ No **Are your dentures/partials comfortable?**
- □ Yes □ No **Do you use denture adhesives or pastes to help secure your dentures/partials?**
- □ Yes □ No **Do you avoid certain foods?**
- □ Yes □ No **Does your denture/partial move, slip or feel loose when you talk, eat, laugh, yawn or sneeze?**
- □ Yes □ No **Do you feel your dentures/partials have decreased the flavor of foods you eat or reduced your thermal sensations?**
- □ Yes □ No **Do you have a hard time cleaning your dentures/ partials, or remaining teeth?**

Any Additional Concerns You Would Like To Discuss With Dr. Correa:

_____
_____
_____

Patient Signature:_____ Date:_____

Medical History

Although dental personnel primarily treat the areas in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or the medications and vitamin and herbal supplements you take, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

PATIENT NAME:_____

Are you under a physician's care now? **□ Yes □ No □ N/A**_____
If yes, please explain:_____

Have you ever been hospitalized or had a major operation? **□ Yes □ No □ N/A**_____
If yes, please explain:_____

Have you ever had a serious head or neck injury? **□ Yes □ No □ N/A**_____

Do you take, or have you taken, Phen Phen, or Redux? **□ Yes □ No □ N/A**_____

Do you take, or have you taken any medications for Osteoporosis? **□ Yes □ No □ N/A** _____

Do you use tobacco? **□ Yes □ No □ N/A**_____

Are you on a special diet? **□ Yes □ No □ N/A**_____

Do you use controlled substances? **□ Yes □ No □ N/A**_____

Are you taking any anticoagulants, blood thinners or aspirin? **□ Yes □ No □ N/A**_____

Are you taking any medications, drugs or vitamins? **□ Yes □ No □ N/A**_____

Please list all medications including non-prescription medications, vitamins, minerals or herbs.
_____
_____
_____

Check any of the following that you are taking or have taken:

□Cortisone Drugs □ Blood Thinners
□Steroids □ Sedatives □ MAO Inhibitors □ Tranquilizers
□ Anti-depressants □ Osteoporosis Medications □ Aspirin Daily

Check any of the following that you are ALLERGIC to:

□ Penicillin □ Amoxicillin □ Other Antibiotics _____
□ Barbituates (Codeine) □ Sedatives □ Iodine □ Latex Rubber
□ Any metals (i.e. nickel, mercury, etc.) □ Aspirin □ Local Anesthetics
□ Allergies to other substances:_____

N/A Indicates Not Answered by Patient

Medical History *Continued from previous page.*

PATIENT NAME:_____

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

□ Aids/Hiv Positive	□ Chest Pains	□ Frequent headaches	□ Irregular Heartbeat	□ Scarlet Fever
□ Alzheimer's	□ Cold Sores	□ Herpes Virus	□ Kidney Problems	□ Shingles
□ Anaphylaxis	□ Glaucoma	□ Congenital Heart Disorder	□ Leukemia	□ Sickle Cell Disease
□ Anemia	□ Convulsions	□ Hay Fever	□ Liver Disease	□ Sinus Trouble
□ Angina	□ Heart Attack	□ Cortisone Medication	□ Low Blood Pressure	□ Spina Bifida
□ Arthritis/Gout	□ Diabetes	□ Heart Murmur*	□ Lung Disease	□ Stomach Disease
□ Drug Addiction	□ Stroke	□ Artificial Heart Valve*	□ Heart Pace Maker*	□ Artificial Joint *
□ Easily Winded	□ Heart Disease	□ Mitral Valve Prolapse *	□ Pain in Jaw Joints	□ Swelling of Limbs
□ Asthma	□ Emphysema	□ Hemophilia	□ Parathyroid Disease	□ Thyroid Disease
□ Blood Disease	□ Hepatitis A	□ Epilepsy or Seizures	□ Psychiatric Care	□ Tonsillitis
□ Blood Transfusion	□ Hepatitis B or C	□ Excessive Bleeding	□ Radiation Treatments	□ Tuberculosis
□ Fever Blisters	□ Excessive Thirst	□ Breathing Problems	□ Recent Weight Loss	□ Tumors/Growths
□ Bruise Easily	□ Ulcers	□ Fainting Spells/Dizziness	□ High Blood Pressure	□ Renal Dialysis
□ Cancer	□ Frequent Cough	□ Hives/Rash	□ Rheumatic Fever*	□ Venereal Disease
□ Chemotherapy	□ Hypoglycemia	□ Rheumatism	□ Frequent Diarrhea	□ Yellow Jaundice
□ Any Auto Immune Disorders				

Have you had any serious illness not listed above: □ Yes □ No □ N/A (Please comment below):

_____

_____

_____

***Condition may require medication prior to treatment**

WOMEN ONLY:

Are you pregnant or trying to get pregnant?	**□ Yes**	**□ No**	**□ N/A**
Are you nursing?	**□ Yes**	**□ No**	**□ N/A**
Are you taking oral contraceptives?	**□ Yes**	**□ No**	**□ N/A**
Are you taking estrogen therapy?	**□ Yes**	**□ No**	**□ N/A**

This is to certify that I, the undersigned, mutually agree to the necessary or advised treatment, including the use of local anesthetics as indicated. Furthermore, I grant permission to any and all health care providers or legal counsel to release my current name, address, phone number and any treatment notes to Dr. Correa or a member of his staff in the event I should I change any of the answers on this medical history. My signature on this form indicates that I have read and understand the above information and that the above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I also understand that any changes to this medical history must be given to Dr. Correa in writing.

Patient Signature:_____ **Date:** _____

Responsible Party if patient is a minor or dependant:_____

TMJ Medical History

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

- ☐ Chronic Fatigue
- ☐ Dental Implants
- ☐ Depression
- ☐ Insomnia
- ☐ Jaw/Joint Surgery
- ☐ Muscle Aches, Spasms
- ☐ Nervousness
- ☐ Neuralgia
- ☐ Osteoporosis
- ☐ Prior Orthodontic Treatment
- ☐ Tonsils/Adenoids Removal
- ☐ Wisdom Teeth Extraction

Other _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please number your **top 4** complaints/symptoms with #1 being the most important, #2 the next important, etc.
2. Then rate your complaints for intensity: Intensity: (0 is NO PAIN and 10 is MOST SEVERE PAIN)

Number		Intensity
1= most important		0-10
____	Back Pain	____
____	Dizziness	____
____	Ear Congestion	____
____	Ear Pain	____
____	Eye Pain	____
____	Facial Pain	____
____	Fatigue	____
____	Headaches	____
____	Jaw Clicking	____
____	Jaw Joint Noises	____
____	Jaw Locking	____
____	Jaw Pain	____
____	Limited Mouth Opening	____

Number		Intensity
1= most important		0-10
____	Muscle Soreness	____
____	Muscle Twitching	____
____	Neck Pain	____
____	Pain when Chewing	____
____	Ringing in the Ears	____
____	Shoulder Pain	____
____	Sinus Congestion	____
____	Throat Pain	____
____	Visual Disturbances	____
	Other - write in:	
____	_____	____
____	_____	____

TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING:

	Practitioner	Specialty	Treatment & approx. date
1.			
2.			
3.			
4.			
5.			

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

HEAD PAIN L= Left R=Right B=Both sides		LOCATION	SEVERITY			DURATION				
			Mild	Moderate	Severe	Seconds	Minutes	Hours	Days	Weeks
L	R B	Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐
L	R B	Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐
L	R B	Top of head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐
L	R B	Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐
L	R B	In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐

Patient Signature: _____ Date: _____

JAW PAIN

L R B Jaw pain - on opening
L R B Jaw pain - while chewing
L R B Jaw pain - at rest

JAW SYMPTOMS

Y ☐ N ☐ Jaw clicks
Y ☐ N ☐ Jaw locks closed
Y ☐ N ☐ Jaw locks open
Y ☐ N ☐ Jaw popping
Y ☐ N ☐ Teeth clenching
Y ☐ N ☐ Teeth grinding

EYE RELATED CONDITIONS

Y ☐ N ☐ Blurred vision
Y ☐ N ☐ Double vision
Y ☐ N ☐ Eye pain
Y ☐ N ☐ Pain or pressure behind the eyes
Y ☐ N ☐ Photophobia (extreme sensitivity to light)

EAR RELATED CONDITIONS

Y ☐ N ☐ Buzzing in the ears
Y ☐ N ☐ Ear congestion
Y ☐ N ☐ Ear pain
Y ☐ N ☐ Hearing loss
Y ☐ N ☐ Pain behind the ear
Y ☐ N ☐ Pain in front of the ear
Y ☐ N ☐ Recurrent ear infections
Y ☐ N ☐ Tinnitus (ringing in the ear)

THROAT, NECK & BACK RELATED CONDITIONS

Y ☐ N ☐ Back pain - lower
Y ☐ N ☐ Back pain - middle
Y ☐ N ☐ Back pain - upper
Y ☐ N ☐ Chronic sore throat
Y ☐ N ☐ Constant feeling of a foreign object in throat
Y ☐ N ☐ Difficulty in swallowing
Y ☐ N ☐ Limited movement of neck
Y ☐ N ☐ Neck pain
Y ☐ N ☐ Numbness in the hands or fingers
Y ☐ N ☐ Sciatica
Y ☐ N ☐ Scoliosis
Y ☐ N ☐ Shoulder pain
Y ☐ N ☐ Shoulder stiffness
Y ☐ N ☐ Swelling in the neck
Y ☐ N ☐ Swollen glands
Y ☐ N ☐ Thyroid enlargement
Y ☐ N ☐ Tightness in throat
Y ☐ N ☐ Tingling in the hands or fingers

MOUTH & NOSE RELATED CONDITIONS

Y ☐ N ☐ Broken teeth
Y ☐ N ☐ Burning tongue
Y ☐ N ☐ Chronic sinusitis
Y ☐ N ☐ Dry mouth
Y ☐ N ☐ Frequent biting of cheek
Y ☐ N ☐ Frequent snoring

LIFESTYLE RELATED CONDITIONS

Y ☐ N ☐ Currently under unusual stress
Y ☐ N ☐ Recent change in lifestyle
Y ☐ N ☐ Recent change in work pattern

HISTORY OF SYMPTOMS

When did your condition first occur? _____

What do you believe to be the cause of your pain or condition? _____

Y ☐ N ☐ Motor vehicle accident
Y ☐ N ☐ Motorcycle accident
Y ☐ N ☐ Work related incident
Y ☐ N ☐ Playground incident
Y ☐ N ☐ Athletic endeavor
Y ☐ N ☐ Fight
Y ☐ N ☐ Fall
Y ☐ N ☐ Accident
Y ☐ N ☐ Illness
Y ☐ N ☐ Injury
Y ☐ N ☐ Unknown

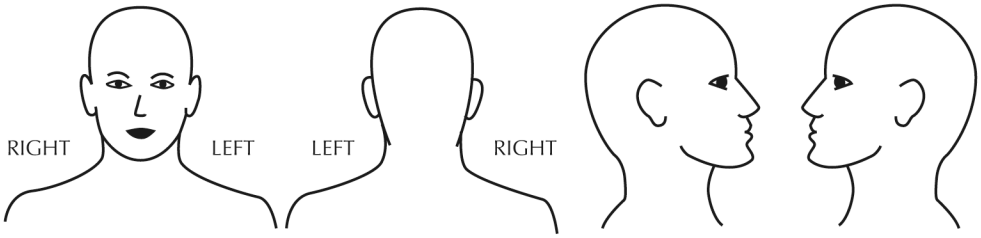
If accident, what was the date? _____

What other information is important to your pain or condition? _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN ||||||
MODERATE PAIN MMM
SEVERE PAIN //////

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating



I give consent to Dr Correa the take radiographs, photographs, study models, and any other diagnostic aids deemed appropriate to make a thorough diagnosis. I further authorize the use of my records to be used by Dr Correa for purposes of training and education at dental meetings, conferences and lectures.

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES
DR. JAMES CORREA

Office Contact: James Correa
Effective date of notice: April 25, 2003

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED
AND HOW YOU CAN ACCESS THIS INFORMATION.

We require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to the inspection and the copying of your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, and requesting that we restrict certain uses and disclosures of your rights.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under law. We may revise our Notice form from time to time. The effective date at the top of this page indicates the date of the most current Notice in effect. You have a right to receive a copy of our most current Notice in effect. If you would like to receive a detailed Notice of Privacy Practices please request a copy at the front desk.

If you have any questions, concerns, or complaints about the Notice or your medical information, please contact Dr. Correa at 949-706-2100

_____ _____
Signature Date

_____
Relationship to Patient