

## Patient Registration

(Please Print)

<b>Patient's Name:</b>				
<b>If Child, Parent's Name:</b>	Last Name	First Name	Initial	Preferred Name
<b>Home Address:</b>	Last Name	First Name	Initial	Preferred Name
	City		State	Zip Code
<b>Ways to Contact You:</b>	( ) -	( ) -	( ) -	( ) -
	Home Phone	Business Phone	Mobile Phone	Fax
	E-mail Address: _____			
	During office hours:		The best <b>way</b> to reach me is: _____	
	The best <b>time</b> to reach me is: _____			
	Marital Status:	Single <input type="checkbox"/>	Married <input type="checkbox"/>	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
		Widowed <input type="checkbox"/>	Divorced <input type="checkbox"/>	Date of Birth: / /
	SS #:	- -	Driver's License #:	State:
<b>If Full-time Student:</b>	Name of School:		City, State:	
<b>Employer's Name:</b>				Occupation:
	Business Address: _____		Suite No: _____	
	City		State	Zip Code
<b>Spouse/Parent:</b>				
Parent's Home Address: (If different from above)	Last Name	First Name	Initial	Preferred Name
	City		State	Zip Code
<b>Ways to Contact Spouse/Parent:</b>	( ) -	( ) -	( ) -	( ) -
	Home Phone	Business Phone	Mobile Phone	Fax
	E-Mail Address: _____			
	During office hours:		The best <b>way</b> to reach me is: _____	
	The best <b>time</b> to reach me is: _____			
	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth: / /		
	SS #:	- -	Driver's License #:	State:
<b>Spouse/Parent Employer's Name:</b>				Occupation:
	Business Address: _____		Suite #: _____	
	City		State	Zip Code



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## PATIENT HEALTH HISTORY

1. How do you feel about getting and keeping a healthy mouth? \_\_\_\_\_
2. How do you feel about the appearance of your teeth? \_\_\_\_\_
3. Are you happy with your smile? If not, what would you like to change about it? \_\_\_\_\_
4. Are you having any dental problems at this time? Yes  No
5. Are you having pain or discomfort at this time? Yes  No
6. Do your gums bleed at any time? Yes  No
7. Do you feel nervous or anxious about having dental treatment? Yes  No
8. Have you ever had a bad experience in the dental office? Yes  No
9. Have you been under the care of a medical doctor during the past 2 years? Yes  No

If yes, for what reason? \_\_\_\_\_

Your Physician's Name: \_\_\_\_\_

Office Address: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Date of Last Complete Medical Physical: \_\_\_\_\_

10. Have you been hospitalized during the past 2 years? Yes  No   
If yes, for what reason? \_\_\_\_\_

11. Have you taken any medicine or drugs during the past two years? Yes  No   
Are you now taking any medicine or drugs (including non-prescription)? Yes  No

If so, please provide a complete list of medications, dosage, and how taken: (use additional paper, if necessary)

Medication	Dosage	Daily Frequency

12. Are you allergic to (i.e. itching, rash, swelling of hands/feet/or eyes) or have you reacted adversely (made sick) to any of the following items? Yes  No

**If yes, please circle:**

Aspirin	Codeine	Darvon	Demerol	Percodan
Vicodin	Lortab	Penicillin	Erythromycin	Tetracycline
Sleeping Pills	Local Anesthetic	Nitrous Oxide Gas	Latex	

Any other medications or substances? If yes, please list: \_\_\_\_\_

### Shannon DentalCare

6840 W. Virginia Parkway, #130

McKinney, Texas 75071

972/562-7999

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## Patient Health History, cont.

13. Have you ever had excessive bleeding you could not control and required special treatment? Yes  No
14. When you climb stairs or take a walk, do you ever have to stop because of pain in your chest, of shortness of breath, or because it makes you very tired? Yes  No
15. Do your ankles swell during the day? Yes  No
16. Do you use more than two pillows to sleep? Yes  No
17. Do you ever wake up from sleep short of breath? Yes  No
18. Do you use any tobacco products? Yes  No
19. Have you lost or gained more than ten pounds in the past year? Yes  No
20. Are you on a special diet? Yes  No
21. Do you experience frequent thirst or frequent need to urinate? Yes  No
22. Have you ever been diagnosed/treated for a tumor or cancer? Yes  No

If yes, please explain: \_\_\_\_\_

23. Circle any of the following conditions which you have had or currently have:

Allergies or Hives	Diabetes	Heart (Mitral) Valve Prolapse	Rheumatic Fever
Anemia	Drug Addiction/Alcoholism	Heart Murmur	Rheumatism
Angina Pectoris (chest pain)	Eating Disorder	Heart Pacemaker	Scarlet Fever
Arthritis	Emphysema	Heart Surgery	Sickle Cell Disease
Artificial Heart Valve	Epilepsy or Seizures	Hemophilia	Shortness of Breath
Artificial Joint of Any Type	Fainting or Dizzy Spells	Hepatitis (any type)	Stroke
Asthma	Family History of Cardiovascular Disease	High Blood Pressure	Thyroid Disease
Blood Transfusion	Fibromyalgia	HIV Positive (AIDS)	Tuberculosis (TB)
Bruise Easily	Genital Herpes	Kidney Disease	Ulcers
Cancer or Tumors	Glaucoma	Liver Disease	Venereal Disease (any type)
Chemotherapy	Hay Fever	Nervousness	Yellow Jaundice
Cold Sores or Fever Blisters	Heart Disease or Attack	Pain in Jaw Joints	X-ray or Cobalt Treatment
Congenital Heart Lesions	Heart Failure	Persistent Coughs	
Cortison Medication		Psychiatric Treatment	

**For women only:** Currently pregnant Yes  No  If yes, expected due date: \_\_\_\_\_

Currently taking Birth Control Medication Yes  No

24. Do you have, or have you had, any disease, condition, or problem not listed? Yes  No

If yes, please explain: \_\_\_\_\_

I confirm that the above information is accurate, true, and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Patient Signature(or Parent/Legal Guardian if Minor):** \_\_\_\_\_

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## Consent to Perform Dentistry

I, \_\_\_\_\_, hereby consent to and authorize Dr. Timothy P. Shannon, DDS, and/or his dental auxiliaries and assigns, to provide and perform any or all of the following dental treatment procedures, including oral surgery, in conjunction with the use of any necessary or advisable radiographs and other diagnostic aids as he deems useful:

1. Preventive periodontal care and maintenance, including topical fluoride application when beneficial;
  2. Application of unfilled resin material, known as "sealants," to the occlusal (bite) grooves of the posterior teeth as a preventive treatment against tooth decay;
  3. Treatment of the soft tissues (gums) in the presence of acute or chronic periodontal disease and/or injury;
  4. Treatment of diseased or injured hard tissues, including teeth with suitable dental restorations (fillings or crowns), root canal therapy, or limited oral surgery (including tooth extraction) as circumstances require;
  5. Replacement of missing teeth with dental prostheses using fixed and/or removable appliances (bridgework; partial or full denture; implant restoration);
  6. Non-surgical evaluation/treatment of the temporomandibular joint, myofacial pain, and/or occlusal dysfunction, including the use of bite splint therapy, and limited or full mouth adjustment/equilibration;
  7. Treatment of malposed (crooked), chipped, or discolored teeth, and/or oral development and growth problems;
  8. Use of conscious sedation techniques (nitrous oxide analgesia; oral medication) to control and manage anxiety or disruptive behavior.
- I understand and accept that there are inherent risks associated with any dental treatment and hereby acknowledge that these risks have/will be explained to me, that I will have the opportunity to ask questions regarding the recommended treatment and its associated risk, and I am satisfied with the explanation given.
  - I understand that there are potential risks and complications associated with the use of local anesthesia, nitrous oxide analgesia, and oral sedative medications, including allergic reaction (itching, tissue rash, breathing difficulty), pain, swelling, bleeding, bruising, hematoma (blood bruise at or near injection site), nausea, vomiting, tingling and/or numbness in area of anesthetized tissues subsequent to treatment for an indeterminate length of time, fainting, and biting of the soft tissues while numb resulting in ulceration/inflammation. I also understand that in rare circumstances the risk may include severe respiratory and cardiovascular complications, including total collapse (stopping of breathing and heart function; oxygen deficiency to the brain leading to possible coma or death). I acknowledge that I have been informed of such risks.
  - I understand that when using the nose piece for nitrous oxide administration, it may leave an indentation or ring around the nose which disappears shortly after the use of the nose piece is discontinued.
  - I understand that during the course of treatment it may be necessary to alter and/or amend the prescribed treatment due to unforeseen circumstances that could not be anticipated earlier. I request and authorize the performance of any additional treatment procedures that are deemed necessary according to the professional judgment of the dentist.
  - I understand and am advised that the overall success of any recommended dental treatment requires that the patient (and parents in the case of a minor) adhere to any and all post-treatment care instructions given by the dentist and/or the dental auxiliaries. In addition, the maintenance of regular re-care visits as scheduled will directly affect the long-term success of any treatment that is given.
  - I understand and authorize the dentist, his dental auxiliaries, and assigns to use any radiographs, photographs, and other diagnostic materials/treatment records for the purpose of teaching, research, and scientific publication.
  - In conclusion, I hereby state that I have read and understand this consent, that all questions with regard to dental procedures have been/will be answered to my satisfaction, and that I may require additional information whenever I deem it necessary to make an informed decision concerning my dental care. I further acknowledge and agree that this "consent to perform dentistry" will remain in effect until such time that I choose to terminate it.

Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Name of Parent or Guardian: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

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