Bollmeier Dental
622-8888
Dr. Ellen Bollmeier
Dr. Anne Bollmeier Mashl

REGISTRATION AND MEDICAL HISTORY

Date _____

Patient Name_____ Preferred Name _____

Address_____

City_____ State____ Zip Code _____ Home Phone (___)_____

E-mail address_____ Work Phone (___)_____

Social Security Number _____ Cell Phone (___)_____

Date of Birth_____ Male/ Female Single/ Married Preferred phone: home/ cell/ work

Employer

Name _____ Phone (___)_____

Address_____ City _____ State ____ Zip Code _____

Primary Insurance Holder - Relationship to patient _____(Exp. Spouse, Parent, etc)

Name _____ Dental Insurance_____

Phone(___)_____ Type of Phone: home/ cell/ work

Address_____ City _____ State ____ Zip Code _____

SSN_____ Date of Birth _____ Employer_____

If you are completing this form for another person, what is your relationship to that person? _____

The name of patient's primary physician(s) is _____ City_____

My last physical examination was on _____

How did you hear about us?_____

Please circle Yes or No to each question. Your answers are confidential:

Are you in good health? Yes No

Has there been any change in your general health within the past year? Yes No

If yes, please explain: _____

Are you taking any medicine(s) including non-prescription medicine? Yes No

If so, what medicine(s) are you taking?_____

Are you taking any dietary supplements or herbal medication on a regular basis? Yes No

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

Damaged or artificial heart valves	Yes No	Stroke	Yes No
Heart murmur	Yes No	Cardiac pacemaker	Yes No
Mitro-valve prolapsed	Yes No	Chest pain upon exertion	Yes No
Rheumatic heart disease	Yes No	Epilepsy/Neurological disease	Yes No
Cardiovascular disease	Yes No	Low Blood Pressure	Yes No
Heart attack	Yes No	Sinus Trouble	Yes No
Angina	Yes No	Asthma	Yes No
Coronary insufficiency	Yes No	Do you carry an inhaler?	Yes No
Coronary occlusion	Yes No	Fainting spells or seizures	Yes No
High blood pressure	Yes No	Anemia	Yes No
Arteriosclerosis	Yes No	Diabetes	Yes No

Joint replacements (eg. knee or hip) Yes No
Type_____ Date_____
Hepatitis/jaundice/liver disease Yes No
Thyroid problems Yes No
Respiratory issues Yes No
Arthritis/ Painful swollen joints Yes No
Stomach ulcer / Hyperacidity Yes No
Kidney problems Yes No
Tuberculosis Yes No
Persistent cough/Cough with blood Yes No
Persistent swollen neck glands Yes No
Sexually transmitted disease (STD) Yes No
Name of STD_____
AIDS or HIV infection Yes No
Problems with mental health Yes No
Cancer Yes No
Type_____ Date_____
Treatment_____
Radiation therapy /chemotherapy Yes No
Type_____ Date_____
Treatment for tumor/growth Yes No

Immune system issues Yes No
Abnormal bleeding Yes No
Required a blood transfusion Yes No
If so, when_____why_____
Wearing removable appliances? Yes No

Allergies

Are you allergic or have you had a reaction to:

Local anesthetics Yes No
Penicillin or other antibiotics Yes No
Name of Antibiotic _____
Sulfa drugs Yes No
Latex Yes No
Aspirin Yes No
Iodine Yes No
Codeine or other narcotics Yes No
Name of narcotic_____
Other _____

Women:

Are you pregnant Yes No
Are you nursing Yes No
Are you taking birth control pills Yes No

Do you have any disease, condition, or problem not listed above? Yes No
If so, explain_____
Chief Dental Complaint_____
Have you had any serious trouble associated with any previous dental treatment? Yes No
If so, explain_____
Do you have any popping or clicking in your jaw joints? Yes No
Do you have any pain in your jaw joints? Yes No
Has your jaw ever locked open or closed? Yes No
Have you ever noticed yourself grinding or clenching your teeth? Yes No
Do you frequently wake up with headaches? Yes No
Have you been told that you snore? Yes No
Are you often tired during the day? Yes No
Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep? Yes No
Do you have high blood pressure or are you on medication to control high blood pressure? Yes No
Have you been tested for obstructive sleep apnea (OSA)? Yes No
Have you been diagnosed with obstructive sleep apnea (OSA)? Yes No
If yes, do you have a CPAP? Yes No
If yes, do you wear your CPAP? Yes No
Do you smoke or use tobacco? Yes No
Type of tobacco_____ How often_____

Are you interested in (please check all that apply):

- ☐ Tooth Whitening
- ☐ Invisalign
- ☐ Oral Sleep Devices
- ☐ Implants
- ☐ Cosmetic Smile Improvement
- ☐ Custom Athletic Mouthguards

I certify that I have read and understand the above and have completed this form to the best of my knowledge. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I will inform my dentist to any changes to these questions.

Signature:_____ Date:_____