Nicholas N. Gadler, DDS, Inc. 366 South Pierce Street, El Cajon, CA 92020

Patient Registration Record *(information provided herein is strictly confidential)*

Today's Date ______________________ *(mm/dd/yyyy)* **Referred by** ______________________

Have you, or any member of your family, ever seen Dr. Gadler before? Yes No If yes, when? ______________

Patient Full Name ____________ / ____ / ____________ Nick Name ______________

Age ________ Gender ____________ Date of Birth ______________ Marital Status ______________

Social Security No ______________ Employer Name ______________

Driver's License No ______________ Occupation ______________

Home Address ______________ Employer Address ______________

Apt/Suite No ______________ Suite No ______________

City/State/ZIP ________ / ____ / ________ City/State/ZIP ________ / ____ / ________

Home Phone ( ) ______________ Work Phone ( ) ______________

Your Dentist ______________ Phone ________ Your Physician ______________ Phone ________

Emergency Contact – Name and Phone No ______________ / ( ) ______________

*** If you are married, please complete the Spouse section below.**
**** If you are a minor or not the insured party, please complete the Responsible Party, Father, Mother sections below.**

*** Spouse Info** *(if married)*

Name ____________ / ____________

Date of Birth ______________

Social Security No ______________

Driver's License No ______________

Employer ______________

Occupation ______________

Employer Address ______________

Suite No ______________

City/State/ZIP ________ / ____ / ________

Work Phone ( ) ______________

**** Responsible Party Info**

Name ____________ / ____________

Relationship to PT ______________

Social Security No ______________

Driver's License No ______________

Employer ______________

Occupation ______________

Employer Address ______________

Suite No ______________

City/State/ZIP ________ / ____ / ________

Work Phone ( ) ______________

**** Father Info**

Name ____________ / ____________

Employer ______________

Employer Address ______________

Suite No ______________

City/State/ZIP ________ / ____ / ________

Work Phone ( ) ______________

**** Mother Info**

Name ____________ / ____________

Employer ______________

Employer Address ______________

Suite No ______________

City/State/ZIP ________ / ____ / ________

Work Phone ( ) ______________

Primary Insurance *(please provide membership card)*

Company Name ______________

Group/Policy No ________ / ________

Name of Insured ________ / ________

Relationship to Patient ______________

SSN ______________ DOB ______________

Secondary Insurance *(please provide membership card)*

Company Name ______________

Group/Policy No ________ / ________

Name of Insured ________ / ________

Relationship to Patient ______________

SSN ______________ DOB ______________

FINANCIAL AGREEMENT: The undersigned agrees, whether he or she signs as agent or as patient, that in consideration of the service to be rendered to the patient, I hereby individually obligate myself to pay the account in accordance with the fees and terms of the Oral Surgeon. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. **Our office reserves the right to charge a fee for failed appointments.**

INSURANCE RELEASE: I hereby authorize Dr. Gadler to furnish to the above named insurance company all information which said insurance company may request. I hereby authorize payment to be made directly to the Oral Surgeon but not to exceed the charges incurred.

SIGNATURE BY RESPONSIBLE PARTY ______________________ DATE ______________

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Medical History

When was your last medical exam? ________________________ *(mm/dd/yyyy)*

Are you presently under a Physician's care?	Yes	No
Are you having pain or discomfort at this time?	Yes	No
Do you feel very nervous about having dental treatment?	Yes	No
Have you ever had a bad experience in a dental office?	Yes	No
Have you been a patient in the hospital during the past two (2) years?	Yes	No
Have you been under the care of a medical doctor during the past two (2) years?	Yes	No
Have you ever had any excessive bleeding requiring special treatment?	Yes	No
When you climb stairs or walk, do you ever have to stop due to chest pain, shortness of breath or being very tired?	Yes	No
Have you been required to restrict your work or activities?	Yes	No
Do your ankles swell during the day?	Yes	No
Do you use more than two (2) pillows to sleep (as ordered by your physician)?	Yes	No
Have you lost or gained more than ten (10) pounds in the last year?	Yes	No
Do you ever wake up from sleep short of breath?	Yes	No
Are you on a special diet or have you ever taken Fen-Phen?	Yes	No
Has your medical doctor ever said you have a cancer or tumor?	Yes	No

	Yes	**No**
Latex Allergy		
Mitral Valve Prolapse		
Heart Failure, Disease, or Attack		
Multiple Myeloma		
Angina Pectoris		
High Blood Pressure		
Heart Murmur		
Rheumatic Fever		
Congenital Heart Lesions		
Scarlet Fever		
Artificial Heart Valves		
Heart Pacemaker		
Artificial Joints or Valves		
Metal Pins or Plates		
Anemia		
Stroke		
Kidney Trouble		
Ulcers		

	Yes	**No**
Emphysema		
Frequent Cough or Cold		
Tuberculosis (TB)		
Asthma or Bronchitis		
Hay Fever		
Sinus Trouble		
Allergies or Hives		
Diabetes		
Thyroid Disease		
Xray or Cobalt Treatment		
Chemotherapy (cancer, leuk)		
Arthritis		
Rheumatism		
Cortisone Medicine		
Glaucoma		
Pain or Popping in Jaw Joints		
Chronic Infection		
Chronic Headaches		

	Yes	**No**
Hepatitis (non A, non B)		
Hepatitis A (infectious)		
Hepatitis B (Serum)		
Liver Disease		
Yellow Jaundice		
Blood Transfusion		
Drug Addiction		
Hemophilia		
Venereal Disease		
Cold Sores		
Genital Herpes		
Epilepsy or Seizures		
Fainting or Dizzy Spells		
Nervousness		
Psychiatric Treatment		
Sickle Cell Disease		
Bruise Easily		
Tonsillitis		

Do you drink alcohol? Yes No If yes, amount consumed per day or per week: ____________________

Do you smoke? Yes No If yes, how much? ____________________ If you quit, how long ago? ____________

Do you use recreational drugs? Yes No If yes, please **specify**: ____________________

Are you currently taking or have you ever taken any of the following medications:
Zoledronate, Zomeda, Pamidronate, Aredia, Alendronate or Fosamax? If yes, please **list**:

Do you take any medicines regularly? Please **name** them:
(including aspirin and any over-the-counter preparation)

Do you have any allergies (i.e. itching, rash, swelling of hands and feet),
drug reactions or any medicines you've been told not to take? Please **list**:

Have you or anyone in your family had a reaction to general anesthesia?
If yes, please **describe** the type of reaction:

(Women Only)	**Yes**	**No**
Have you ever been treated for breast cancer?		
Are you now pregnant?		
Practicing birth control or taking birth control pills?		
Anticipate becoming pregnant in the near future?		

WARNING: Birth control pills are less effective while taking anti-biotics. Extra precaution is needed until your next menstrual cycle.

All of the preceding answers are true and correct to the best of my knowledge. If I ever have a change in my health, or if my medicines change, I will inform the Oral Surgeon at the next appointment without fail.

____

Date Nicholas N. Gadler DDS Inc.

____

Signature of Patient, Parent or Guardian