Dr. Jay Patel
Tel. 732-986-3690 | Fax 732-601-4865
Email: info@dentsed.com

DENTAL SEDATION SERVICES

Patient Registration Form

Patient Name:	
DOB:	
Sex:	
Marital Status:	
Street Address: City, State, Zip:	
Telephone:	
Email:	

Emergency Contact Information

Name:	
Relationship:	
Phone Number:	

Medical Insurance Information

Medical Carrier:	
ID#:	
Group #:	
Provider Name:	
Claims Address:	

Secondary Insurance Information

Carrier:	
ID#:	
Group #:	
Provider Name:	
Claims Address:	

Subscriber Information

Name:	
Date of Birth:	
Relation to Patient:	
Street Address: City, State, Zip:	

Dentist Information

Dentist Name:	
Dentist Location:	
Dentist Office Name:	

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Patient Medical Questionnaire

All medical information collected is strictly confidential and is not shared without your permission. The information provided is used only by the anesthesiologist to determine your specific anesthesia plan. Please answer all questions truthfully to ensure no interactions with the anesthesia and safeguard your health.

Height: _____ Weight: _____

Allergies: (to any Medications, Food, Latex) ☐ Y ☐ N
If yes, please list:

Specifically to Egg/Soy products: ☐ Y ☐ N

Medications: (Please list all medications, dosages, and when they are taken)

Physicians: (Please list your physician(s), the practice location, and date of your most recent visit)

Have you had anesthesia for any other procedures? (Please list) ☐ Y ☐ N

Has anyone in your family ever had any severe complications with anesthesia?

Women ONLY:
Are you currently, planning on, or potentially pregnant or nursing? ☐ Y ☐ N
Date of last menstrual cycle? _____

Do you smoke? ☐ Y ☐ N
Do you use any recreational drugs? ☐ Y ☐ N
Do you have any history of alcohol or substance abuse? ☐ Y ☐ N
Please explain:

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Please check off any relevant medical conditions
You may use the section at the end to fill in any conditions you do not see listed

CARDIOVASCULAR (HEART)
☐ Abnormal heart rhythm/Irregular heart beat
☐ Artificial heart valves
☐ Cardiac (heart) stents
☐ Chest pain/discomfort
☐ Congenital heart defect
☐ Congestive heart failure
☐ Heart attack
☐ Heart murmur
☐ Heart Problem
☐ Heart surgery
☐ High Cholesterol
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Mitral valve prolapse
☐ Pacemaker or AICD

PULMONARY (LUNGS)
☐ Asthma
Last Episode: _____
☐ Allergies (SEASONAL)
☐ Bronchitis
☐ Breathing difficulty
☐ COPD
☐ Chronic cough
☐ Emphysema
☐ Obstructive Sleep Apnea
☐ Pneumonia
☐ Respiratory disease
☐ Shortness of breath
☐ Sinus problems

NEUROLOGICAL (BRAIN/NERVES)
☐ Anxiety
☐ Brain injury/Trauma
☐ Epilepsy
☐ Fainting
☐ Fibromyalgia
☐ Parkinson's disease
☐ Seizures
☐ Stroke/TIA
☐ Tingling/Numbness

BEHAVIOR/DEVELOPMENTAL
☐ ADHD
☐ Autism
☐ Bipolar/Schizophrenia
☐ Cerebral palsy
☐ Depression
☐ Developmental Delay
☐ Down Syndrome
☐ Mental Retardation
☐ Sensory disorder
☐ Special needs

MUSCULOSKELETAL
☐ Arthritis
☐ Artificial Joints
☐ Muscle disorder
☐ Muscular dystrophy
☐ Osteoporosis/Osteopenia
☐ Paralysis

GASTROINTESTINAL (STOMACH/INTESTINES)
☐ Acid Reflux
☐ Crohn's disease
☐ GERD
☐ IBS
☐ Stomach ulcers
☐ Severe Gag reflex

ENDOCRINE (HORMONE)
☐ Diabetes mellitus Type I / II
☐ Hypothyroid
☐ Hyperthyroid
☐ Addison's disease
☐ Cushing's disease

LIVER/KIDNEY
☐ Cirrhosis
☐ Hepatitis
☐ Jaundice
☐ Kidney disease/failure
☐ Liver disorder

☐ Anemia
☐ Bleeding abnormality
☐ Blood disease
☐ Bruise easily
☐ Circulatory condition
☐ Prolonged bleeding

CANCER
☐ Chemotherapy
Last Treatment: _____
☐ Radiation therapy
Last Treatment: _____
☐ Type of cancer(s):
_____
_____

INFECTIOUS DISEASE
☐ AIDS/HIV
☐ Contagious disease
☐ Herpes
☐ Hepatitis
☐ Tuberculosis

OTHER:
☐ Rheumatoid arthritis
☐ Chronic sinus / Nose bleeds
☐ Please list any conditions **NOT** LISTED the doctor should be aware of:

I hereby certify that the information I have provided herein is true and accurate to the best of my knowledge. RELEASE OF INFORMATION: I hereby authorize Dental Sedation Services to release any or all information acquired in the course of my examination and/or treatment. I understand this may include the release of any medial or other information required in the processing of claims for payment.

Print Name: _____

Signature: _____ Date: _____

Date Modified: 03/2018