IOWA WISDOM TEETH
SAFE. AFFORDABLE. CONVENIENT.

NEW PATIENT REGISTRATION

Patient First Name _____ Middle Name _____ Last Name _____

Street Address _____ State _____ Zip Code _____

Social Security Number _____ Email Address _____

Home Phone _____ Cell Phone _____

Best Method of Contact: ☐ Call ☐ Text ☐ Email

Can we send appointment confirmations via text to this number? ☐ Yes ☐ No

Date of Birth _____ Age _____ Sex _____ Height _____ Weight _____

Please write down WHY you are here today. _____

_____

_____

****The following questions pertain to the individual having the wisdom teeth extraction****

Have you been treated in a hospital within the last 5 years? ☐ Yes ☐ No

If yes, please explain: _____

_____

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

_____

Are you currently taking any prescription medications? ☐ Yes ☐ No

If yes, please list below along with dosage and frequency: _____

_____

Are you allergic to any of the following?

☐ Novocaine	☐ Propofol	☐ Tape Adhesive	☐ Penicillin	☐ Percocet
☐ Codeine	☐ Ketamine	☐ Tylenol	☐ Demerol	☐ Lortab
☐ Eggs	☐ Hydrocodone	☐ Phenergan	☐ Fentanyl	☐ Pentothal
☐ Morphine	☐ Aspirin	☐ Ibuprofen	☐ Latex	☐ Ketorolac

Please describe reaction to any positive entries above: _____

_____

Please list any food/drug allergies that are not listed above: _____

_____

(Continued on the back side)

Do you have or have had any of the following?

- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Easy Bruising
- ☐ Glaucoma
- ☐ Heard Defect
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Diabetes
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Nephritis
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Issues
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ Osteoporosis
- ☐ Malignant Hypothermia
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Snoring
- ☐ Pneumonia

Please explain any positive entries above: _____

_____

Are there any medical conditions not mentioned above that are part of your medical history? ☐ Yes ☐ No

If yes, please explain:_____

_____

What surgeries have you had in the past? _____

_____

Any issues with the anesthesia for your surgeries? ☐ Yes ☐ No

Does anyone in your blood relative family have issues with anesthesia? ☐ Yes ☐ No

Have you ever been sedated for a medical or dental procedure? ☐ Yes ☐ No

If yes, were there any complications?_____

_____

Do you have a cold? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Do you smoke or vape? ☐ Yes ☐ No If yes, how many cigarettes per day?_____

The answers to the following questions will be kept confidential. Please answer them honestly. They are part of your medical record and will not be reported to any law enforcement agencies. Your answers are important as they help us to provide safe anesthesia.

Have you used any of the following during the past year?

☐ Marijuana ☐ MDMA ☐ Heroin ☐ Mushrooms ☐ Meth ☐ Psychedelics ☐ Cocaine ☐ Other _____

If you answered yes to any of the above, when was the last time you used them? _____

Have you suffered from prescription drug abuse of any kind? ☐ Yes ☐ No

If yes, please explain:_____

_____

_____ _____

Patient Home Dental Office City

_____ _____

Name of physician or healthcare provider City

Do you wear braces? ☐ Yes ☐ No If yes, who is your orthodontist? _____

How did you hear about us? ☐ Facebook ☐ Google ☐ Family/Friend ☐ Dentist/Referral

Who will be the individual responsible for accompanying the patient home?

_____ _____ _____

Name Relationship Cell Phone Number

I confirm that all of the above health history information is correct to the best of my knowledge

_____ _____ _____

Patient or Parent Guardian Signature Date

OFFICE USE ONLY

Referral_____ Prior Auth Completed_____ VDI Completed_____

Insurance_____ Prepayment/Deposit Collected_____ Pano In Record_____

Medicaid_____ Consents Signed_____