Elite Dental Club
Implant Center & General Dentistry
Dr. Raouf Morcos, DDS
4556 Warm Springs Ave Wildwood FL 34785
Phone 352-670-4777 ♦Fax 352-577-9646

## Patient Registration (Please Print Clearly)

Name: _____ DOB _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Child

Address (street, city, state, zip): _____

_____

Phone Number: _____

Email Address: _____

(By providing an email address we assume its okay to email appointment reminders, insurance claims etc.)

Primary Care Physician: _____

Phone Number: _____

Emergency Contact: _____

Phone Number: _____

List of current medications: _____

_____

_____

_____

Do you have any allergies to any medications? Yes No
Do you require antibiotics prior to dental procedures? Yes No
Any current major medical problems at this time that the Doctor should be made aware of? Yes No
Do you have dental insurance? Yes No

**Dental History**

| | | |
|---|---|---|
| Yes No | Are you experiencing any discomfort? If yes, how would you rate your discomfort from 1-10, with 10 being the highest? | Pain level. Please circle one<br>1 2 3 4 5 6 7 8 9 10 |

| | |
|---|---|
| How would you rate your smile on a scale of 1 to 10, with 10 being the highest? | 1 2 3 4 5 6 7 8 9 10 |

| | | | |
|---|---|---|---|
| Yes No | Do you snore? | Yes No | Do you take a fluoride supplement? |
| Yes No | Do you have bleeding gums? | Yes No | Do you use tobacco (smoke or chew)? |
| Yes No | Do you have bad breath? | Yes No | Do you drink coffee or tea? |

| | | | | |
|---|---|---|---|---|
| Yes No | Do you grind your teeth? | | Yes No | Do you bite pencils? |
| Yes No | Do you play sports? | | Yes No | Do you grind your teeth at night? |
| Yes No | Do you suck your thumb? | | Yes No | Do you have any missing teeth? |
| Yes No | Have you ever worn braces? | | Yes No | Do you bite your nails? |
| Yes No | Are you interested in clear aligners? | | Yes No | Do you bite your lips? |
| Yes No | Are you sensitive to hot, cold, or sweets? | | Yes No | Interested in having whiter/brighter teeth? |
| Yes No | Do you have difficulty brushing your teeth? | | Yes No | Have you ever had an accident that damaged your teeth? |
| Yes No | Have you ever received Periodontal (Gum) Therapy? | | Yes No | Does your jaw pop or do you hear clicking when chewing? |

**Medical History**

| | | | | |
|---|---|---|---|---|
| Yes No | Are you under a physician's care? | | Yes No | Have you been hospitalized or had a major operation? |
| Yes No | Have you had serious head or neck injury? | | Yes No | Do you use controlled substances? |
| Yes No | Do you use recreational substances? | | Yes No | Women: Are you pregnant, trying to get pregnant, or breast feeding? |

If you answered yes to any of the about, please explain:

**Are you allergic or do you react adversely to any of the following;**

| | | | | |
|---|---|---|---|---|
| Yes No | Aspirin | | Yes No | Local anesthetics (Novocain) |
| Yes No | Acrylic | | Yes No | Metal |
| Yes No | Barbiturates, sedatives/sleeping pills | | Yes No | Milk Protein |
| Yes No | Codeine | | Yes No | Sulfa Drugs |
| Yes No | Latex | | Yes No | Tetracycline |
| Yes No | Penicillin or another antibiotic? If yes please specify: | | | |

**Do you currently have or previously had;**

| | | | | |
|---|---|---|---|---|
| Yes No | AIDS/HIV Positive | | Yes No | Convulsions |
| Yes No | Alzheimer's Disease | | Yes No | Cortisone Medicine |
| Yes No | Anaphylaxis | | Yes No | Diabetes |
| Yes No | Anemia | | Yes No | Drug Addiction |
| Yes No | Angina | | Yes No | Easily Winded |
| Yes No | Arthritis/Gout | | Yes No | Emphysema |
| Yes No | Artificial Heart Valve | | Yes No | Endocarditis |
| Yes No | Asthma | | Yes No | Epilepsy/Seizures |
| Yes No | Artificial Joint | | Yes No | Excessive Bleeding |
| Yes No | Blood Disease | | Yes No | Excessive Thirst |
| Yes No | Blood Transfusion | | Yes No | Fainting Spells/Dizziness |
| Yes No | Breathing Problem | | Yes No | Frequent Cough |
| Yes No | Bruise Easily | | Yes No | Frequent Diarrhea |
| Yes No | Cancer | | Yes No | Frequent Headaches |
| Yes No | Chemotherapy | | Yes No | Glaucoma |
| Yes No | Chest Pains | | Yes No | Hay Fever |

| | | | | |
|---|---|---|---|---|
| Yes No | Cold Sores/Fever Blisters | | Yes No | Heart Attack |
| Yes No | Congenital Heart Disorder | | Yes No | Heart Murmur |
| Yes No | Heart Pacemaker | | Yes No | Psychiatric Care |
| Yes No | Heart Trouble/Disease | | Yes No | Radiation Treatments |
| Yes No | Hemophilia | | Yes No | Recent Weigh Loss |
| Yes No | Hepatitis A | | Yes No | Renal Dialysis |
| Yes No | Hepatitis B or C | | Yes No | Rheumatic Fever |
| Yes No | Herpes | | Yes No | Rheumatism |
| Yes No | High Blood Pressure | | Yes No | Scarlet Fever |
| Yes No | Hives/Rash | | Yes No | Shingles |
| Yes No | Hypoglycemia | | Yes No | Sickle Cell Disease |
| Yes No | Human Papillomavirus | | Yes No | Sinus Problem |
| Yes No | Irregular Heart Beat | | Yes No | Sleep Apnea |
| Yes No | Kidney Problems | | Yes No | Spinal Bifida |
| Yes No | Leukemia | | Yes No | Stomach/Intestinal Disease |
| Yes No | Liver Disease | | Yes No | Stroke |
| Yes No | Low Blood Pressure | | Yes No | Swelling of Limbs |
| Yes No | Lung Disease | | Yes No | Thyroid Disease |
| Yes No | Mitral Valve Prolapse | | Yes No | Tonsillitis |
| Yes No | Osteoporosis | | Yes No | Tuberculosis |
| Yes No | Pain in Jaw Joints | | Yes No | Tumors or Growths |
| Yes No | Parathyroid Disease | | Yes No | Ulcers |
| Yes No | Parkinson's Disease | | Yes No | Venereal Disease |
| Yes No | Pins/Rods/Stints /Shunts | | Yes No | Yellow Jaundice |

**Are you currently or have you taken any of the following medications and/or supplements in the past 12 months;**

| | | | | |
|---|---|---|---|---|
| Yes No | Anticoagulants | | Yes No | Herbal supplements |
| Yes No | Aspirin-Daily | | Yes No | Insulin or Diabetes |
| Yes No | Contraceptives | | Yes No | Nitroglycerine |
| Yes No | Heart Medications | | Yes No | Phen-Fen o Redux |
| Yes No | High Blood Pressure Medication | | Yes No | Tranquilizer |
| Yes No | Bisphosphonates (used to treat osteoporosis, such as Fosamax, Boniva, Actonel, and Zometa | | | |
| Yes No | Antibiotics or Sulfa Drugs: if yes please specify; | | | |

**X-Rays & Pictures**

I understand that all x-rays/pictures taken at Elite Dental Club are complementary and are utilized in house ONLY. In the event I would like a copy for my records or to be forwarded to any other party I understand I will be responsible to pay for said x-rays/pictures.

Signature: _____ Date:_____

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Print Name: _____ DOB: _____

## Medical Information Release Form (HIPAA Release)

**Release of Information**
I authorize the release of information including the diagnosis, records, appointments, examination results, medication dose changes, and claims information.

This information may be released to:

☐ - Spouse _____

☐ - Child(ren) _____

☐ - Other _____

**Messages**
Please call _____

If unable to reach me:
☐ - Leave a detailed message OR ☐ - Leave a message asking me to return your call

**E-mail Messages**
☐ - Use my e-mail address to send messages.

My e-mail address is _____

This Release of Information will remain in effect until terminated by me in writing. This release specifically excludes any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Signature: _____ Date: _____