Elite Dental Club
Implant Center & General Dentistry
Dr. Raouf Morcos, DDS
4556 Warm Springs Ave Wildwood FL 34785
Phone 352-6704777 ♦Fax 352-577-9646

Patient Registration (Please Print Clearly)

First Name: _____ Last Name: _____ DOB _____

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

_____

Phone Number: _____
Okay to send text messages to this number? □ No □ Yes

Email Address: _____

Okay to send emails to this address? □ No □ Yes

Primary Care Physician: _____

Phone Number: _____

Emergency Contact: _____

Phone Number: _____

Preferred Pharmacy: _____

List of current medications: _____

_____

_____

What brings you into the office today: _____

Are you currently experiencing any oral pain? ☐ Y ☐ N

Do you have any allergies to any medications? ☐ Y ☐ N

Do you require antibiotics prior to dental procedures? ☐ Y ☐ N

Any current major medical problems at this time that the Doctor should be made aware of? ☐ Y ☐ N

Dental & Medical History

Dental History

☐ Y ☐ N	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 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

☐ Y ☐ N	Do you snore?	☐ Y ☐ N	Do you take a fluoride supplement?
☐ Y ☐ N	Do you have bleeding gums?	☐ Y ☐ N	Do you use tobacco (smoke or chew)?
☐ Y ☐ N	Do you have bad breath?	☐ Y ☐ N	Do you drink coffee or tea?
☐ Y ☐ N	Do you grind your teeth?	☐ Y ☐ N	Do you bite pencils?
☐ Y ☐ N	Do you play sports?	☐ Y ☐ N	Do you grind your teeth at night?
☐ Y ☐ N	Do you suck your thumb?	☐ Y ☐ N	Do you have any missing teeth?
☐ Y ☐ N	Have you ever worn braces?	☐ Y ☐ N	Do you bite your nails?
☐ Y ☐ N	Are you interested in clear aligners?	☐ Y ☐ N	Do you bite your lips?
☐ Y ☐ N	Are you sensitive to hot, cold, or sweets?	☐ Y ☐ N	Interested in having whiter/brighter teeth?
☐ Y ☐ N	Do you have difficulty brushing your teeth?	☐ Y ☐ N	Have you ever had an accident that damaged your teeth?
☐ Y ☐ N	Have you ever received Periodontal (Gum) Therapy?	☐ Y ☐ N	Does your jaw pop or do you hear clicking when chewing?

Medical History

☐ Y ☐ N	Are you under a physician's care?	☐ Y ☐ N	Have you been hospitalized or had a major operation?
☐ Y ☐ N	Have you had serious head or neck injury?	☐ Y ☐ N	Do you use controlled substances?
☐ Y ☐ N	Do you use recreational substances?	☐ Y ☐ N	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;

☐ Y ☐ N	Aspirin	☐ Y ☐ N	Local anesthetics (Novocain)
☐ Y ☐ N	Acrylic	☐ Y ☐ N	Metal
☐ Y ☐ N	Barbiturates, sedatives/sleeping pills	☐ Y ☐ N	Milk Protein

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

☐ Y ☐ N	Codeine		☐ Y ☐ N	Sulfa Drugs
☐ Y ☐ N	Latex		☐ Y ☐ N	Tetracycline
☐ Y ☐ N	Penicillin or another antibiotic? If yes please specify:			

Please check any conditions that you currently or previously have had;

☐ Y ☐ N	AIDS/HIV Positive		☐ Y ☐ N	Hepatitis B or C
☐ Y ☐ N	Alzheimer's Disease		☐ Y ☐ N	Herpes
☐ Y ☐ N	Anaphylaxis		☐ Y ☐ N	High Blood Pressure
☐ Y ☐ N	Anemia		☐ Y ☐ N	Hives or Rash
☐ Y ☐ N	Angina		☐ Y ☐ N	Hypoglycemia
☐ Y ☐ N	Arthritis/Gout		☐ Y ☐ N	Human Papillomavirus
☐ Y ☐ N	Artificial Heart Valve		☐ Y ☐ N	Irregular Heart Beat
☐ Y ☐ N	Asthma		☐ Y ☐ N	Kidney Problems
☐ Y ☐ N	Artificial Joint		☐ Y ☐ N	Leukemia
☐ Y ☐ N	Blood disease		☐ Y ☐ N	Liver Disease
☐ Y ☐ N	Blood transfusion		☐ Y ☐ N	Low Blood Pressure
☐ Y ☐ N	Breathing Problem		☐ Y ☐ N	Lung Disease
☐ Y ☐ N	Bruise Easily		☐ Y ☐ N	Mitral Valve Prolapse
☐ Y ☐ N	Cancer		☐ Y ☐ N	Osteoporosis
☐ Y ☐ N	Chemotherapy		☐ Y ☐ N	Pain in Jaw Joints
☐ Y ☐ N	Chest Pains		☐ Y ☐ N	Parathyroid Disease
☐ Y ☐ N	Cold Sores/Fever Blisters		☐ Y ☐ N	Parkinson's Disease
☐ Y ☐ N	Congenital Heart Disorder		☐ Y ☐ N	Pins/Rods/Stints /Shunts
☐ Y ☐ N	Convulsions		☐ Y ☐ N	Psychiatric Care
☐ Y ☐ N	Cortisone Medicine		☐ Y ☐ N	Radiation Treatments
☐ Y ☐ N	Diabetes		☐ Y ☐ N	Recent Weigh Loss
☐ Y ☐ N	Drug Addiction		☐ Y ☐ N	Renal Dialysis

Please check any conditions that you currently or previously have had;

☐ Y ☐ N	Easily Winded	☐ Y ☐ N	Rheumatic Fever
☐ Y ☐ N	Emphysema	☐ Y ☐ N	Rheumatism
☐ Y ☐ N	Endocarditis	☐ Y ☐ N	Scarlet Fever
☐ Y ☐ N	Epilepsy or Seizures	☐ Y ☐ N	Shingles
☐ Y ☐ N	Excessive Bleeding	☐ Y ☐ N	Sickle Cell Disease
☐ Y ☐ N	Excessive Thirst	☐ Y ☐ N	Sinus Problem
☐ Y ☐ N	Fainting Spells/Dizziness	☐ Y ☐ N	Sleep Apnea
☐ Y ☐ N	Frequent Cough	☐ Y ☐ N	Spinal Bifida
☐ Y ☐ N	Frequent Diarrhea	☐ Y ☐ N	Stomach/Intestinal Disease
☐ Y ☐ N	Frequent Headaches	☐ Y ☐ N	Stroke
☐ Y ☐ N	Glaucoma	☐ Y ☐ N	Swelling of Limbs
☐ Y ☐ N	Hay Fever	☐ Y ☐ N	Thyroid Disease
☐ Y ☐ N	Heart Attack	☐ Y ☐ N	Tonsillitis
☐ Y ☐ N	Heart Murmur	☐ Y ☐ N	Tuberculosis
☐ Y ☐ N	Heart Pacemaker	☐ Y ☐ N	Tumors or Growths
☐ Y ☐ N	Heart Trouble/Disease	☐ Y ☐ N	Ulcers
☐ Y ☐ N	Hemophilia	☐ Y ☐ N	Venereal Disease
☐ Y ☐ N	Hepatitis A	☐ Y ☐ N	Yellow Jaundice

Please check any medications and/or supplements taken in the past 12 months;

☐ Y ☐ N	Anticoagulants	☐ Y ☐ N	Herbal supplements
☐ Y ☐ N	Aspirin-Daily	☐ Y ☐ N	Insulin or Diabetes
☐ Y ☐ N	Contraceptives	☐ Y ☐ N	Nitroglycerine
☐ Y ☐ N	Heart Medications	☐ Y ☐ N	Phen-Fen o Redux
☐ Y ☐ N	High Blood Pressure Medication	☐ Y ☐ N	Tranquilizer
☐ Y ☐ N	Bisphosphonates (used to treat osteoporosis, such as Fosamax, Boniva, Actonel, and Zometa		
☐ Y ☐ N	Antibiotics or Sulfa Drugs: if yes please specify;		

Signature: _____ Date:_____