PATIENT REGISTRATION FORM

RICHARD R. PENCE, DDS, PA

Responsible Party Information

Name: ____

Address: ____

City: ________________________ **State**: _____ **Zip**: _________

Home Phone: (____)__________ **Work Phone**: (___)____________

Social Security #: ___________ **Referred By**: ________________

Patient Information: Check if Same as Above ____, (Start with Birthday below :)

Name: ____

Address: ____

City: ________________________ **State**: _____ **Zip**: _________

Home Phone: (____)_________ **Work Phone**: (___)_____________

Birthday: ____________________ **Age**: _______ **Sex**: _______

Marital Status: **Single _____** **Married _____** **Divorced _____**
Separated _____ **Widowed _____**

Employment Status: **Full Time _____** **Part Time _____**
Retired _____ **Not Employed _____**

Student Status: **Full Time _____** **Part Time _____**
Not a Student _____

Date: ___________ **Form Completed** _________________________

Medical History

Physician's name ___________________________ Date of last exam _______________

Birthdate _______________________

Do you have any of the following? Please indicate with a check mark.

___ Any heart problems
___ High blood pressure
___ Low blood pressure
___ Circulatory problems
___ Radiation treatments
___ Excessive bleeding
___ Allergies to anesthetics
___ Allergies to medicines or drugs
___ Allergies to _______________

___ Anemia
___ Arthritis
___ Asthma
___ Hepatitis
___ Herpes
___ Malignancies
___ Mumps
___ Psychiatric care
___ Rheumatic Fever
___ Scarlet Fever

___ Sinus problems
___ Stroke
___ Typhoid Fever
___ Tuberculosis
___Ulcer
___Venereal Disease

Are you pregnant? _____________ Blood Pressure: S_____/ D_____/______

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.

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Date ____________________ Your Signature ________________________________

STOP BANG Questionnaire

Height _____ inches/cm Weight _____ lb/kg Age _____

Male/Female

BMI _____

Collar size of shirt: S, M, L, XL, or _____ inches/cm Neck circumference*

_____ cm

1. **Snoring**

Do you snore loudly (louder than talking or loud enough to be heard through

closed doors)?

Yes No

2. **Tired**

Do you often feel tired, fatigued, or sleepy during daytime?
Yes No

3. **Observed**

Has anyone observed you stop breathing during your sleep?
Yes No

4. **Blood pressure**

Do you have or are you being treated for high blood pressure?
Yes No

5. **BMI**

BMI more than 35 kg/m2?
Yes No

6. **Age**

Age over 50 yr old?
Yes No

7. **Neck circumference**

Neck circumference greater than 16" ?
Yes No

8. **Gender**

Gender male?
Yes No