KDSA@KANDORDENTAL.COM
5515 Vista View Way
Oviedo, FL 32765

(407)542-4935
(407)-542-4934
FAX
(407)542.0756

REGISTRATION FORM

Name: _____ DOB: _____

Street Address: _____

City: _____ State _____ ZIP: _____

Phone: _____

Email: _____

How did you hear about Kandor Dental Assistant School?

_____

Allergies / Medical Information: _____

Emergency Contact:

Name: _____Relation: _____

Phone: _____

Language Preference for communication:

• English • Spanish

Payment agreement:

• One payment – Full Payment

• Two payments – Partial Payment

• Three payments – Payment Plan

Method of Payment:

• Cash • Credit Card • Check - Check #_____

Credit Card # _____ Exp. Date: _____

• VISA • Master Card

Signature: _____ Date: _____

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APPLICATION FOR ADMISSION

Application for School Year:_____Anticipated Started Date:_____

Application for admission to

- Dental Assistant Course
- Expanded Function
- Radiology Certification

Name: _____ DOB: _____

Gender: • Male • Female

Street Address: _____

City: _____ State _____ ZIP: _____

Phone: _____

Email: _____

How did you hear about Kandor Dental Assistant School?

_____

Allergies/ Medical Information: _____

Emergency Contact:

Name: _____Relation: _____

Phone: _____

Previous Education:

High School: _____

College: _____

Language Preference for communication:

MEDICAL HISTORY FORM

Medical History: *For the following questions please mark (X) your response to the following questions and fill in additional information requested.*

Physician's Name:_____

Address:_____

Phone:_____

Are you under the care of a physician	☐ Yes ☐ No
If yes, please explain the reason.	
Have you had a serious illness or operation	☐ Yes ☐ No
Are you taking or have you recently taken any perscriptions or over the counter medicine(s)?	
Have you ever or are you currently takin or scheduled to bein taking any medications, alendronate (Fosamax), risedronate (Actonel) or ibadronate (Boniva) for osteoporosis or Paget's disease?	☐ Yes ☐ No IF yes please state when Date of treatment began: _____
Where you treated for Hypercalcemia or skeltal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain?	☐ Yes ☐ No
Are you pregnant, suspect that you maybe or trying to concieve?	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No

Are you allergic to or have a reaction to any of the following listed:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Sulfa ☐ Local Anesthetic

Now or in the past, have you had

AIDS or HIV positive	☐ Yes	☐ No		Emphysema	☐ Yes	☐ No	
Abnormal Bleeding	☐ Yes	☐ No		Epilepsy	☐ Yes	☐ No	
Alcohol Abuse	☐ Yes	☐ No		Excessive bleeding or bruising tendency, anemia or bleeding disorder	☐ Yes	☐ No	
Anemia	☐ Yes	☐ No		Eye, ear, nose or throat condition	☐ Yes	☐ No	
Arthritis	☐ Yes	☐ No		Fainting spells, seizures, epilepsy or neurological problem	☐ Yes	☐ No	
Artificial Bones	☐ Yes	☐ No			☐ Yes	☐ No	
Artificial Joint Replacement	☐ Yes	☐ No		Frequent headaches, colds or sore throats	☐ Yes	☐ No	
Asthma, Hayfever, Sinus trouble or Hives	☐ Yes	☐ No		Hemophilia	☐ Yes	☐ No	
Birth defects or hereditary problems	☐ Yes	☐ No		Hepatitis, jaundice or liver problem	☐ Yes	☐ No	
Bone fractures, any major accidents	☐ Yes	☐ No		High or low blood pressure	☐ Yes	☐ No	
Blood Transfusion	☐ Yes	☐ No		History of eating disorder (anorexia, bulimia)	☐ Yes	☐ No	
Cancer, tumor, radiation treatment or chemotherapy	☐ Yes	☐ No		Glaucoma	☐ Yes	☐ No	
Cardiovascular problem	☐ Yes	☐ No		Kidney problems	☐ Yes	☐ No	
Angina Pectoris, Chest Pain	☐ Yes	☐ No		Liver Disease	☐ Yes	☐ No	
Arteriosclerosis	☐ Yes	☐ No		Loss of weight recently, poor appetite	☐ Yes	☐ No	
Artificial Heart Valve	☐ Yes	☐ No			☐ Yes	☐ No	
Coronary Insufficiency	☐ Yes	☐ No		Mental health disturbance or depression	☐ Yes	☐ No	
Congenital Heart Defect	☐ Yes	☐ No		Osteoporosis	☐ Yes	☐ No	
Heart Attack,	☐ Yes	☐ No		Psychiatric Problems	☐ Yes	☐ No	
Heart Surgery	☐ Yes	☐ No		Polio, mononucleosis, tuberculosis, pneumonia	☐ Yes	☐ No	
Heart Murmur	☐ Yes	☐ No		Problems of the immune system	☐ Yes	☐ No	
Heart Trouble	☐ Yes	☐ No		Reflux	☐ Yes	☐ No	
Inborn Heart Defects	☐ Yes	☐ No		Rheumatoid or arthritic conditions	☐ Yes	☐ No	
Pacemaker	☐ Yes	☐ No		Skin disorder	☐ Yes	☐ No	
Rheumatic Heart Disease	☐ Yes	☐ No		Stomach ulcer or hyperacidity	☐ Yes	☐ No	
Shortness of Breath or Swelling Ankles	☐ Yes	☐ No		Tired easily	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No		Tonsil or adenoid conditions	☐ Yes	☐ No	

[illegible]	☐	[illegible]		[illegible]	☐	[illegible]	No
[illegible]	☐	[illegible]	[illegible]	[illegible]	[illegible]	Yes	☐ No
Drug Abuse	☐	Yes	☐ No	Venereal Disease	☐	Yes	☐ No
Endocrine or thyroid problems	☐	Yes	☐ No	Vision, hearing, tasting or speech difficulties	☐	Yes	☐ No