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

(407)542-4935
(407)-542-4934

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

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

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

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:

? English ? Spanish

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 Drugs Local Anesthetic

Now or in the past, have you had

Condition	Yes	No	Condition	Yes	No
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

Diabetes	Yes	No	Thyroid Problem	Yes	No
Difficulty Breathing	Yes	No	Tuberculosis	Yes	No
Drug Abuse	Yes	No	Venereal Disease	Yes	No
Endocrine or thyroid problems	Yes	No	Vision, hearing, tasting or speech difficulties	Yes	No