HEALTH HISTORY & REGISTRATION

Patient Number_____

PATIENT INFORMATION

PATIENT'S NAME: Last_____ First_____ Middle Initial_____

SEX: M F BIRTHDATE_____ Age:_____ Soc. Sec.#_____ TODAY'S DATE _____

If Patient is a Minor, give Parent's or Guardian's Name _____

Who may we thank for referring you to our office? _____

Reason for this visit _____

RESPONSIBLE PARTY INFORMATION

NAME: Last_____ First_____ Middle _____ MARITAL STATUS_____

HOME PHONE_____ WORK PHONE _____

CELL PHONE_____ E-MAIL_____ OTHER _____

RESIDENCE:

Street_____ Apt.#_____ How Long at this address _____

City_____ State_____ Zip_____

MAILING ADDRESS:

Street_____ Apt.#_____

City_____ State_____ Zip_____

PREVIOUS ADDRESS (if less than 3 yrs.)

Street_____ Apt.#_____ How Long at this address _____

City_____ State_____ Zip_____

SOCIAL SECURITY #_____ BIRTHDATE_____ DRIVERS LICENSE #_____ RELATION TO PATIENT_____

EMPLOYER_____ OCCUPATION_____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____

Employer_____

NO. YEARS EMPLOYED_____

OCCUPATION _____

SOC. SEC.# _____

WORK PHONE_____

BIRTHDATE_____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____

ADDRESS _____

CITY_____ STATE_____ ZIP_____

PHONE_____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

City_____ State_____ Zip _____

Insured's Employer _____

Insured's Soc.Sec.# _____

Group #_____ Local #_____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

City_____ State_____ Zip _____

Insured's Employer _____

Insured's Soc.Sec.# _____

Group #_____ Local #_____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking time to completely fill out this questionnaire.

DENTAL HISTORY

	YES	NO		YES	NO
How long since you have seen a dentist?			Have you had any Periodontal (Gum) treatments?	☐	☐
Last complete dental exam, date?			Do your gums bleed, or feel tender or irritated?	☐	☐
Last full mouth x-rays, date? (16 small films or panoramic)			Are your teeth sensitive to hot, cold, sweets, pressure?	☐	☐
Are you apprehensive about dental treatment?	☐	☐	Are you unhappy with the appearance of your teeth?	☐	☐
Are you having problems now?	☐	☐	Are you aware of grinding or clenching your teeth?	☐	☐
What?			Do you have headaches, earaches, or neck pains?	☐	☐
Is your present dental health poor?	☐	☐	Would you like to have whiter teeth?	☐	☐
Do you wear dentures? (Partials or Full)	☐	☐	Would you like your smile to look better or different?	☐	☐
Are you unhappy with your dentures?	☐	☐	Do you regularly use dental floss?	☐	☐
Would you like to know more about permanent replacements?	☐	☐			

Name of previous dentist?_____ City:_____ State:_____

How do you feel about your teeth? _____

Please RANK the following in the order in which they would keep you from having dental treatment.

Fear of pain #_____ Lack of concern #_____ Cost of treatment #_____ Missing work time#_____

MEDICAL HISTORY

	YES	NO		YES	NO
Do you have any current health problems?	☐	☐	What medications are you currently taking?		
Are you under a physicians care now?	☐	☐	Are you pregnant?	☐	☐
For what?			Do you use (circle) cigars/cigarettes, pipe or chewing tobacco?	☐	☐

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	AIDS/ARC/HIV Pos.	Bruise easily	Angina Pectoris	Hepatitis A (infectious)
Emphysema	High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)	Heart Murmur
Hepatitis C	Asthma	Rheumatic Fever	Liver Disease	Hay Fever
Congenital Heart Lesions	Blood Transfusion	Sinus Trouble	Mitral Valve Prolapse	Drug Addiction
Allergies or Hives	Artificial Heart Valve	Diabetes	Heart Pacemaker	Fever Blisters
Thyroid Disease	Heart Surgery	Epilepsy or Seizures	Radiation Treatment	Artificial Joints (Hip, Knee)
Nervousness	Arthritis	Anemia	Psychiatric Treatment	Cortisone Medicine
Stroke	Glaucoma	Pain in Jaw Joints	Kidney Trouble	Chemotherapy (Cancer, Leukemia)
Alcoholism	Ulcers	Venereal Disease (Syphilis, Gonorrhea, etc.)		Hemophilia (Bleeding Problems)
Cosmetic Surgery				

ARE YOU ALLERGIC TO OR HAVE REACTED ADVERSELY TO ANY OF THE FOLLOWING?

Aspirin Local Anesthetic Erythromycin Latex (Balloons,Gloves. Etc.) Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other foods, medications or substances?_____

If yes, please list:_____

Is there any other medical or dental Information that you feel I should know about? _____

FAMILY PHYSICIAN_____ PHONE #_____

CONSENT:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

Patient Signature (Parent or Chid): _____ Date:_____

Dentist Signature:_____

Int._____ Date:_____ Int._____ Date:_____ Int._____ Date:_____ Int._____ Date:_____ Int._____ Date:_____

Int._____ Date:_____ Int._____ Date:_____ Int._____ Date:_____ Int._____ Date:_____ Int._____ Date:_____