Patient Number A B C

HEALTH HISTORY and REGISTRATION

PATIENT INFORMATION

Patient's Last Name _____ First _____ Middle Initial _____ Sex: ☐ M ☐ F Birthdate _____ Age _____

Soc. Sec. No. _____ If patient is a minor, give parent's or guardian's name _____ Today's Date _____

Whom may we thank for referring you to our office? _____ Reason for this visit _____

RESPONSIBLE PARTY INFORMATION

Responsible Party's Last Name _____ First _____ Middle Initial _____ Marital Status _____

Residence Street _____ Apt. No. _____ City _____ State _____ Zip _____

Mailing Address Street _____ Apt. No. _____ City _____ State _____ Zip _____

How long at this address _____ Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Previous Address (if less than 3 yrs) Street _____ Apt. No. _____ City _____ State _____ Zip _____

Soc. Sec. No. _____ Birthdate _____ Driver's License _____ Relation to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

Name _____ Relationship _____

Street _____ Apt. No. _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insurance Co. Email _____

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 _____

Insurance Co. Email _____

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 the time to completely fill out this questionnaire.

DENTAL HISTORY

	YES	NO
How long since you have seen a dentist? _____		
Last complete **dental exam**, date: _____		
Last full mouth **x-rays**, date: (16 small films or panoramic) _____		
Are you having **problems** now?	☐	☐
What? _____		
Do you wear **dentures**? (partials or full)	☐	☐
Are you unhappy with your dentures?	☐	☐
Would you like to know more about **permanent replacements**?	☐	☐
Are you apprehensive about dental treatment?	☐	☐
Have you had any **periodontal (gum) treatments**?	☐	☐
Do your gums **bleed**, or feel tender or irritated?	☐	☐
Are your teeth **sensitive** to hot, cold, sweets, pressure? (circle)	☐	☐
Are you unhappy with the **appearance** of your teeth?	☐	☐
Are you aware of **grinding** or **clenching** your teeth?	☐	☐
Do you have **headaches**, **earaches**, or **neck pains**?	☐	☐
Have you worn **braces** on your teeth (orthodontics)?	☐	☐
Do you have **discolored** teeth that bother you?	☐	☐
Would you like your simle to look better or different?	☐	☐
Do you regularly use **dental floss**?	☐	☐

How do you feel about your teeth? _____

Name of Previous Dentist _____

City / State _____

Family Physician _____

Phone _____

Patient Signature (Parent or Guardian of child)

_____

Date of Patient Signature _____

Dentist Signature _____

MEDICAL HISTORY

	YES	NO
Do you have any current health problems?	☐	☐
Are you under a physician's care now?	☐	☐
For what? _____		
What medications are you currently taking? _____		
Have you ever taken Fen-Phen/Redux?	☐	☐
Are you pregnant?	☐	☐
Do you use cigars, cigarettes, pipe, or chewing tabacco? (circle)	☐	☐

PLEASE CHECK YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV pos.	☐	☐	Fainting	☐	☐	Psychiatric care	☐	☐
Anaphylaxis	☐	☐	Food allergies	☐	☐	Rapid weight gain/loss	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation treatment	☐	☐
Arthritis (rheumatism)	☐	☐	Headaches	☐	☐	Respitatory disease	☐	☐
Artificial heart valves	☐	☐	Heart murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Artificial joints	☐	☐	Heart problems (please describe)	☐	☐	Shingles	☐	☐
Asthma	☐	☐				Shortness of breath	☐	☐
Atopic (allergy prone)	☐	☐	_____			Skin rash	☐	☐
Back problems	☐	☐	Hemophilia (abnormal bleeding)	☐	☐	Spina Bifida	☐	☐
Blood disease	☐	☐	Herpes	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Hepatitis	☐	☐	Surgical implant	☐	☐
Chemical dependency	☐	☐	High blood pressure	☐	☐	Swelling of feet or ankles	☐	☐
Chemotherapy	☐	☐	Jaw pain	☐	☐	Thyroid disease or malfunction	☐	☐
Circulatory problems	☐	☐	Kidney disease or malfunction	☐	☐	Tobacco habit	☐	☐
Cortisone treatments	☐	☐	Liver disease	☐	☐	Tonsilitis	☐	☐
Cough (peristent)	☐	☐	Material allergies (latex)	☐	☐	Tuberculosis	☐	☐
Cough up blood	☐	☐	Mittral valve prolapse	☐	☐	Ulcer/Colitis	☐	☐
Diabetes	☐	☐	Nervous problems	☐	☐	Venereal disease	☐	☐
Epilepsy	☐	☐	Pacemaker/heart surgery	☐	☐	Osteoporosis	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO THE FOLLOWING MEDICATIONS?

(circle) Aspirin Nitrous Oxide Local Anasthetic Codeine Erythromycin Penicillin Latex (balloons, gloves)

Are you aware of being allergic to any other medications or substances? _____ If yes, please list:

_____

Is there any other Medical or Dental information that you feel I should know about you? _____