HEALTH HISTORY & REGISTRATION

Patient Number_____ A B C

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: ❑ M ❑ F BIRTHDATE _____ AGE _____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. OF YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME Last _____ First _____ MI ____

EMPLOYER _____ OCCUPATION _____ # OF YEARS _____

SOC. SEC. # _____ BIRTHDATE _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____

DENTAL INSURANCE INFORMATION (PRIMARY)

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

DENTAL INSURANCE INFORMATION (SECONDARY)

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

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?		
Is your present dental health POOR?	❑	❑
Do you wear DENTURES (Partial 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? (check)	❑	❑
Are you UNHAPPY with the APPEARANCE of 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 smile to LOOK BETTER or DIFFERENT?	❑	❑
Do you REGULARLY use DENTAL FLOSS?		
Name of Previous Dentist		
City State		
How do you feel about your teeth?		

Please RANK the following (1-10, with 10 being the highest level) 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
Do you have any CURRENT HEALTH PROBLEMS?	❑	❑
Are you under a PHYSICIAN'S CARE now?	❑	❑
WHAT?		
What MEDICATIONS are you currently taking		
Have you ever used a BISPHOSPHONATE MEDICATION?	❑	❑
(Brand Names: Fosamax, Actonel, Atelvia, Didronel, Boniva)		
Are you PREGNANT?	❑	❑
Do you use ❑ CIGARS / CIGARETTES ❑ PIPE ❑ CHEWING TOBACCO?	❑	❑

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	❑	❑	Respiratory Disease	❑	❑
Artificial Heart Valves	❑	❑	Heart Murmur	❑	❑	Rheumatic / Scarlet Fever	❑	❑
Artificial Joints	❑	❑	Heart Problems	❑	❑	Shingles	❑	❑
Asthma	❑	❑	Describe: _____			Shortness of Breath	❑	❑
Atopic (Allergy Prone)	❑	❑	Hemophilia	❑	❑	Skin Rash	❑	❑
Back Problems	❑	❑	Herpes	❑	❑	Spina Bifida	❑	❑
Blood Disease	❑	❑	Hepatitis	❑	❑	Stroke	❑	❑
Cancer	❑	❑	High Blood Pressure	❑	❑	Surgical Implant	❑	❑
Chemical Dependency	❑	❑	Jaw Pain	❑	❑	Swelling of Feet / Ankles	❑	❑
Chemotherapy	❑	❑	Kidney Disease / Malfunction	❑	❑	Thyroid Disease / Malfunction	❑	❑
Circulatory Problems	❑	❑	Liver Disease	❑	❑	Tobacco Habit	❑	❑
Cortisone Treatments	❑	❑	Material Allergies	❑	❑	Tonsillitis	❑	❑
Cough (Persistent)	❑	❑	(Latex, Wool, Metal, Chemicals)			Tuberculosis	❑	❑
Cough Up Blood	❑	❑	Mitral Valve Prolapse	❑	❑	Ulcer / Colitis	❑	❑
Diabetes	❑	❑	Nervous Problems	❑	❑	Venereal Disease	❑	❑
Epilepsy	❑	❑	Pacemaker / Heart Surgery	❑	❑			

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

	YES	NO		YES	NO		YES	NO
Aspirin	❑	❑	Codeine	❑	❑	Latex (Balloons, Gloves, Etc.)	❑	❑
Nitrous Oxide	❑	❑	Erythromycin	❑	❑	Other	❑	❑
Local Anesthetic	❑	❑	Penicillin	❑	❑	List: _____		

IS THERE ANY OTHER MEDICAL OR DENTAL INFORMATION YOU FEEL I SHOULD KNOW ABOUT?

FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____

PATIENT SIGNATURE (PARENT OF CHILD) _____ **DATE** _____

DENTIST SIGNATURE _____