Date:_____

REGISTRATION FORM

Name:_____
Last First Middle

Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Address:_____
Street Apt# City State Zip

Home Phone:_____ _____ Business Phone_____ _____ Cell _____ _____
Birthdate:_____ Sex: M ☐ F ☐ Height:_____ Weight:_____
Month Day Year

Occupation:_____ If student, name of school/college_____
Employer:_____ Social Security# _____

Emergency Contact:_____ Relationship:_____ Phone:_____

Spouse/ Parent/ Guardian's Name _____ Relationship to Patient_____

Whom may we thank for referring you?_____ Phone:( )_____
RESPONSIBLE PARTY (Only if different than above)
Name of person responsible for this account:_____ Relationship to Patient:_____

Address:_____
Street Apt# City State Zip

Home Phone:( )_____Work Phone:( )_____Cell Phone:( )_____
Birthdate_____ Social Security #:_____
Employer:_____ Phone:( )_____

INSURANCE INFORMATION

Name of Insured:_____ Relationship to Patient:_____ _____
Birthdate:_____ Social Security #:_____
Month Day Year

Name of Employer:_____ Union or Local #:_____
Work Phone:( )_____ Insurance Company_____
Policy/ID#_____ Group#:_____
Do you have any additional insurance? YES ☐ NO ☐ If yes, complete the following:
Name of insured_____ Relationship to Patient:_____
Birthdate_____ Social Security # _____
Month Day Year

Name of Employer:_____ Union or Local #_____ Date Employed:_____
Work Phone:( )_____ Policy/ID#:_____

Insurance Company:_____ Group#:_____

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.
If I do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to the effect collection of this account or future outstanding accounts.

_____
Patient or Responsible Party

_____
Date State Driver's License#

HEALTH HISTORY

MEDICAL INFORMATION

If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.

Have you had any of the following diseases or problems?

	Yes	No
1) Active Tuberculosis	☐	☐
2) Persistent cough greater than a 3 week duration	☐	☐
3) Cough that produces blood	☐	☐
Are you in good health?	☐	☐
Has there been any change in your general health within the past year?	☐	☐
Are you now under the care of physician?	☐	☐

If yes, what is/are the condition(s) being treated?

_____

Date of last physical examination:_____

Physician: _____ ( )_____
Name Phone

Address:_____
City/State Zip

Physician:_____ ( )_____
Name Phone

Address:_____
City/State Zip

	Yes	No
Have you had any serious illness, operation or been hospitalized in the past 5 years?	☐	☐
If yes, what was the illness or problem?_____		
_____		
Are you taking or have you recently taken any medicine(s) including non-prescription?	☐	☐
If yes, what medicine(s) are you taking?		
Prescribed:_____		
_____		
Over the Counter:_____		
_____		
Vitamins, natural or herbal preparations and/or diet supplements:_____		
_____		
Are you taking, or have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	☐	☐
Do you drink alcoholic beverages?	☐	☐
If yes, how much alcohol did you drink in the last -24 hours?_____		
-In the past week?_____		
Are you alcohol and/or drug dependent?	☐	☐
If yes, have you received treatment?_____		
Do you use drugs or other substances for recreational purposes?	☐	☐
If yes, please list:_____		
Frequency of use (daily, weekly, etc.):_____		
Do you use tobacco (smoking, snuff, chew)?	☐	☐
If yes, how interested are you in stopping? (circle one)		
Very/Somewhat/Not interested		
Do you wear contact lenses?	☐	☐

Are you allergic to or have you had a reaction to?	**Yes**	**No**
Local anesthetics	☐	☐
Aspirin	☐	☐
Penicillin or other antibiotics	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐
Sulfa drugs	☐	☐
Codeine or other narcotics	☐	☐
Latex	☐	☐
Iodine	☐	☐
Hayfever/seasonal allergies	☐	☐
Animals	☐	☐

Food (specify)_____
Metals (specify)_____
Other (specify)_____
To yes responses, specify type of reaction:_____
_____
_____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐
If yes, when was this operation done?_____		
If you answered yes to the above, have you had any complications or difficulties with your prosthetic joint?	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐

If yes, what antibiotic and dose?_____
Name of physician or dentist:_____
Phone: ( )_____

WOMEN ONLY

Are you or could you be pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐

I certify that I have read and understand the above and it is correct to the best of my knowledge.

_____
Name Date

Have you had any of the following diseases or problems?

	Yes	No
Abnormal bleeding	☐	☐
AIDS or HIV infection	☐	☐
Anemia	☐	☐
Rheumatoid arthritis	☐	☐
Asthma	☐	☐
Blood transfusion	☐	☐
If yes, date:_____		
Cancer/Chemotherapy/Radiation Treatment	☐	☐
Cardiovascular disease	☐	☐
If yes, specify below:		
____Angina ___Heart murmur		
____Arteriosclerosis ___High blood pressure		
____Artificial heart valves ___Low blood pressure		
____Congenital heart defects ___Mitral valve prolapse		
____Congestive heart failure ___Pacemaker		
____Coronary artery disease ___Rheumatic heart		
____Damaged heart valves disease/Rheumatic		
____Heart attack fever		
Chest pain upon exertion	☐	☐
Chronic pain	☐	☐
Disease, drug or radiation-induced immunosupression	☐	☐
Diabetes. If yes, specify below:	☐	☐
_____Type 1 (Insulin dependent) _____Type 2		
Dry Mouth	☐	☐
Eating disorder. If yes, specify:_____	☐	☐
Epilepsy	☐	☐
Fainting spells or seizures	☐	☐
Gastrointestinal disease	☐	☐
G.E. Reflux/persistent heartburn	☐	☐
Glaucoma	☐	☐
Hemophilia	☐	☐

	Yes	No
Hepatitis, jaundice or liver disease	☐	☐
Recurrent Infections	☐	☐
If yes, what type of infection:_____		
Kidney problems	☐	☐
Mental health disorders	☐	☐
If yes, specify_____		
Malnutrition	☐	☐
Night sweats	☐	☐
Neurological disorders	☐	☐
If yes, specify_____		
Osteoporosis	☐	☐
Persistent swollen glands in neck	☐	☐
Respiratory problems. If yes, specify below:	☐	☐
_____Emphysema _____Bronchitis, etc.		
Severe headaches/migraines	☐	☐
Severe or rapid weight loss	☐	☐
Sexually transmitted disease	☐	☐
Sinus trouble	☐	☐
Sleep disorder	☐	☐
Sores or ulcers in the mouth	☐	☐
Stroke	☐	☐
Systemic lupus erythematosus	☐	☐
Tuberculosis	☐	☐
Thyroid problems	☐	☐
Ulcers	☐	☐
Excessive urination	☐	☐
Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐
Please explain:_____		
_____		
_____		

DENTAL INFORMATION

	Yes	No
Do your gums bleed when you brush?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Do you have earaches or neck pains?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Do you wear removable dental appliances?	☐	☐
Do you feel pain in any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you ever experienced any of the following in your jaw?		
-clicking	☐	☐
-pain (joint, ear, side of face)	☐	☐
-difficulty in opening or closing	☐	☐
-difficulty in chewing	☐	☐
Do you have frequent headaches?	☐	☐

	Yes	No
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you had a serious/difficult problem associated with any previous dental treatment?	☐	☐
If yes, explain:_____		
_____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
How would you describe your current dental problem?		
_____		
Date of your last dental exam:_____		
Date of your last dental x-rays:_____		
What was done at that time?_____		
_____		
How do you feel about the appearance of your teeth?		
_____		

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____
Signature of patient/legal guardian Date

FOR COMPLETION BY DENTIST
Comments on patient interview concerning health history:
Significant findings from questionnaire or oral interview:

Dental management considerations:

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date Comments Signature of patient & dentist

_____
_____
_____
_____