Patient Number _____ A B C

HEALTH HISTORY & REGISTRATION

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. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____ (LAST / FIRST / MIDDLE)

EMPLOYER _____ OCCUPATION _____ ( ) NO. YEARS EMPLOYED

SOC. SEC. # _____ BIRTHDATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY, STATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

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. _____ 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? (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 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 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?	☐	☐
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 tobacco? (circle)	☐	☐

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

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

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

Aspirin, Nitrous Oxide, Local Anesthetic, Codeine, Erythromycin, Penicillin, Latex (balloons, gloves, etc.)

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

If yes, please list:

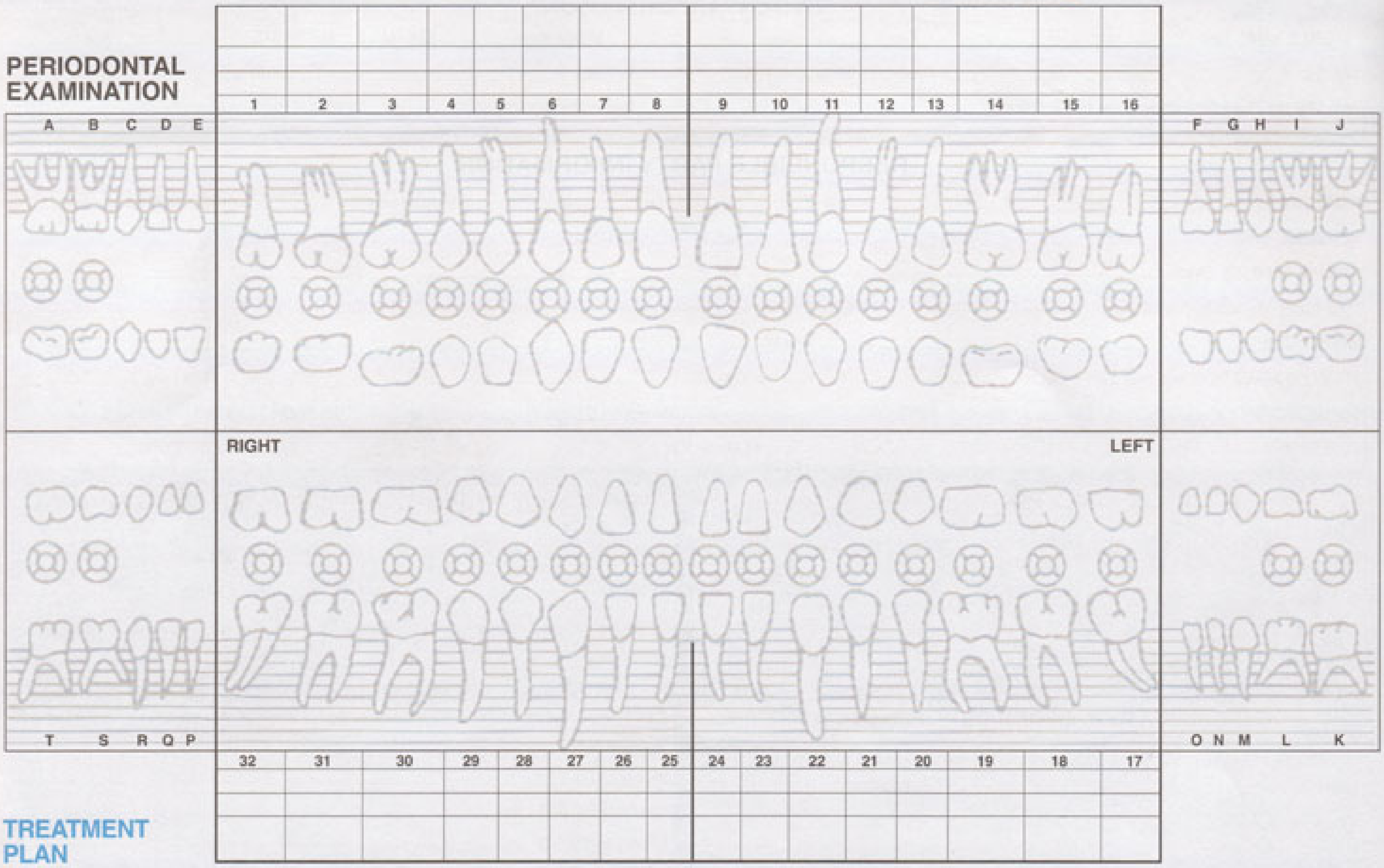
Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

DIAGNOSIS: MISSING TEETH and EXISTING PROBLEMS

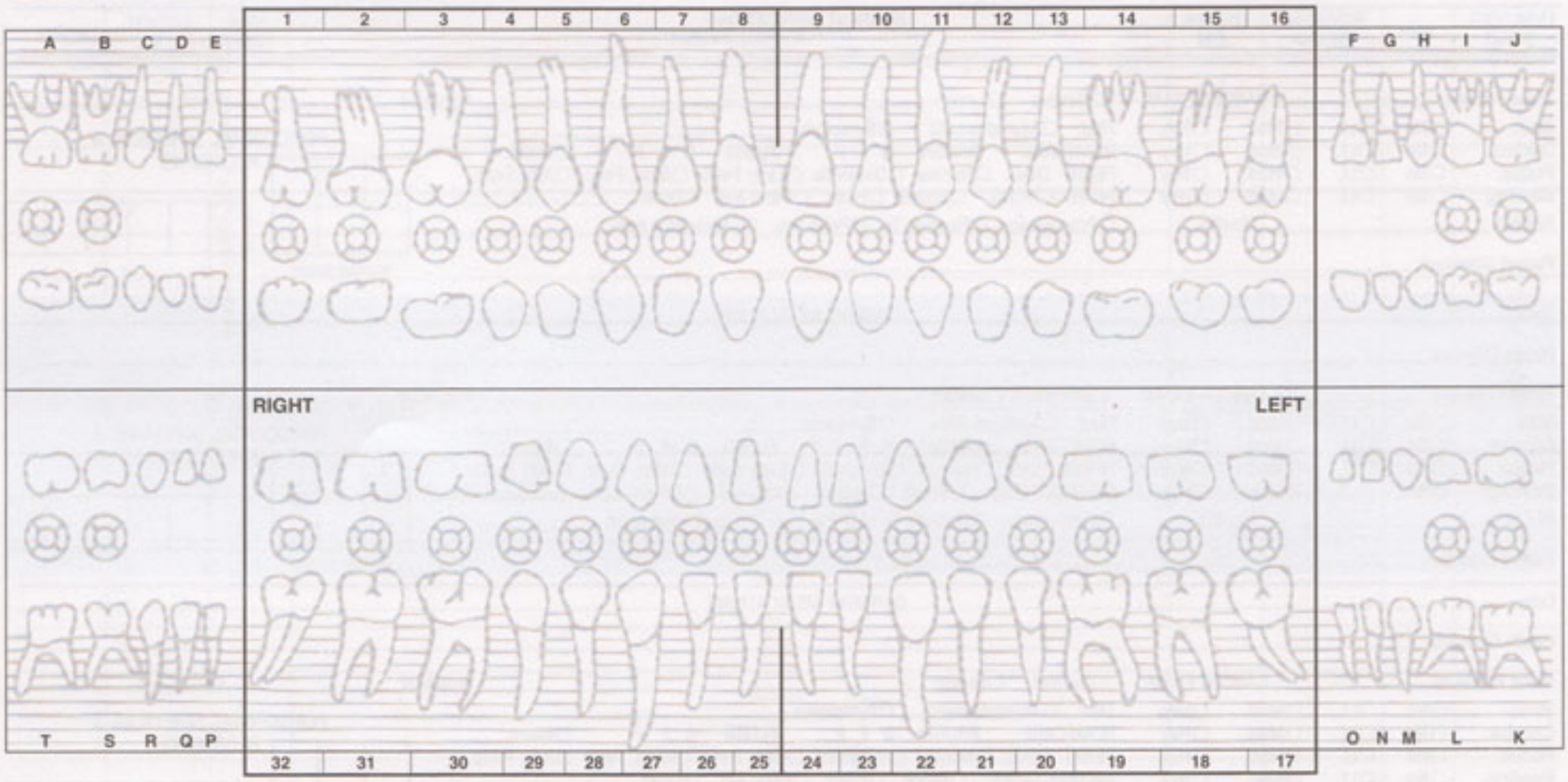
PERIODONTAL EXAMINATION



TREATMENT PLAN

DATE DIAGNOSED	TOOTH #	SUR-FACE	DESCRIPTION OF SERVICE	ADA CODE	FEE	CO-PAY	DATE DIAGNOSED	TOOTH #	SUR-FACE	DESCRIPTION OF SERVICE	ADA CODE	FEE	CO-PAY
			EXAMINATION										
			X-RAY: PANORAMIC: FMX: BWX:										
			DIAGNOSTIC MODELS										
			PROPHYLAXIS (CLEANING)										
			QUADRANTS SCALING & CURETTAGE										
			NITROUS-OXIDE GAS										

COMPLETED TREATMENT



INITIAL PERIODONTAL EXAM:

GINGIVAL INFLAMMATION:	☐ Slight	☐ Moderate	☐ Severe
SOFT PLAQUE BUILDUP:	☐ Slight	☐ Moderate	☐ Heavy
HARD CALCULUS BUILDUP:	☐ Light	☐ Moderate	☐ Heavy
STAINS:	☐ Light	☐ Moderate	☐ Heavy
HOME CARE EFFECTIVENESS:	☐ Good	☐ Fair	☐ Poor
PERIODONTAL CONDITION:	☐ Good	☐ Fair	☐ Poor
PERIODONTAL DIAGNOSIS:	☐ Normal	☐ Gingivitis	
PERIODONTITIS:	☐ Early	☐ Moderate	☐ Advanced

MUCOGINGIVAL DEFECTS #s: _____

CLINICAL DATA:

OCCLUSION: ☐ Class I ☐ Class II ☐ Class III ☐ Crossbite: _____

T.M.J. EXAM: ☐ Normal ☐ Popping ☐ Deviation ☐ Tooth Wear ☐ Pain

INITIAL SOFT TISSUE EXAM:

☐ Lips ☐ Floor of Mouth ☐ Palate ☐ Tongue ☐ Neck & Nodes

PATIENT'S TREATMENT DECISIONS:

☐ DOCUMENTATION OF DENTAL RECORD COMPLETED

☐ PATIENT INFORMED OF TX. RECOMMENDATIONS AND CONSENTS TO TX. (ALTERNATIVES DISCUSSED.)

☐ PATIENT WANTS NO TX. OR PARTIAL TX. INFORMED OF CONSEQUENCES AND RISKS INVOLVED.

INITIAL X-RAY FINDINGS:

X-RAYS TAKEN: ☐ FM-PAS ☐ BWX ☐ PANO. ☐ OTHER _____

☐ NO BONE LOSS

☐ SLIGHT BONE LOSS (04600)

☐ MODERATE BONE LOSS (04700)

☐ MAJOR BONE LOSS (04800)

☐ BEGINNING FURCATION (04700)

☐ ADVANCED FURCATION (04800)

☐ OTHER: _____

QUADRANTS	UR	UL	LR	LL

SHADE

Teeth	Upper	Lower
Cents		
Lats		
Cusp		
Posts		

PERIODONTAL SCREENING & RECORDING

SEXTANT SCORE

MONTH DAY YEAR

EXISTING PROSTHESIS:

MAX: _____ DATE PLACED: _____ CONDITION: _____

MAND: _____ DATE PLACED: _____ CONDITION: _____

REFERRALS:

PERIO: _____ ORTHO: _____ ENDO: _____

ORAL SURG: _____ MD: _____ OTHER: _____

NOTES

CONSENT

The undersigned hereby authorizes the 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 my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

PERIODIC EXAMINATION HEALTH HISTORY UPDATE

Date: CURRENT MEDICATIONS:
Health Changes:
Blood Pressure: CANCER EXAM: ☐Normal ☐Lesion: Hyg/Asst: Dr.
Stain: ☐No ☐Lt. ☐Mod. ☐Hvy. TMJ: ☐Asymptomatic ☐Symptoms
Calculus: ☐No ☐Lt. ☐Mod. ☐Hvy. HOMECARE: BRUSH: G F P FLOSS: G F P ☐Maint.
Plaque: ☐No ☐Lt. ☐Mod. ☐Hvy. PERIO DIAG: ☐Normal ☐Gingivitis ☐Early Perio ☐Mod. Perio ☐Adv. Perio
Bleeding: ☐No ☐Lt. ☐Mod. ☐Hvy. INSTRUCTIONS: ☐Brush ☐Floss ☐Perio Aid ☐Other:
RECALL: Months ☐Prophylaxis: ☐Fluoride Tr. ☐Perio Pro. ☐Check Next Appt:
Patient Signature:
PERIODONTAL SCREENING & RECORDING
SEXTANT SCORE M D Y

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PERIODONTAL SCREENING & RECORDING
SEXTANT SCORE M D Y

RECORD OF SERVICES

DATE	TOOTH #	SUR-FACE	SERVICES RENDERED	PROD. NO.	SERVICE CODE	FEE	RECALL DATE

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