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		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 (please describe)	☐	☐	Shingles	☐	☐
Asthma	☐	☐				Shortness of breath	☐	☐
Atopic (Allergy Prone)	☐	☐	Hemophilia (Abnormal bleeding)	☐	☐	Skin rash	☐	☐
Back problems	☐	☐	Herpes	☐	☐	Spina Bifida	☐	☐
Blood disease	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High blood pressure	☐	☐	Surgical implant	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Swelling of feet or ankles	☐	☐
Chemotherapy	☐	☐	Kidney disease or malfunction	☐	☐	Thyroid disease or malfunction	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tobacco habit	☐	☐
Cortisone treatments	☐	☐	Material allergies (latex, wool, metal, chemicals)	☐	☐	Tonsillitis	☐	☐
Cough (persistent)	☐	☐				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?

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 ____

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