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?	☐	☐
Have you ever used a BISPHOSPHONATE MEDICATION? (Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva)	☐	☐
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 — Local Anesthetic — Erythromycin — Latex (balloons, gloves, etc.)
Nitrous Oxide — Codeine — Penicillin

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 ________