DENTAL REGISTRATION AND HEALTH HISTORY

DATE_____

Patients Name_____How do you prefer to be addressed?_____

Mailing Address _____City _____ State _____ Zip _____

Sex: M F Age:_____ Birth date: _____ Single Married Widow Separated Divorced SS# _____

Home Phone Number: _____ Work Phone Number: _____

Occupation: _____ Employer: _____

Employer's Address: _____ City _____ State _____

If Student, name of School / College: _____ City _____ State _____ PT Full

Whom may we thank for referring you to our office: _____

If the person responsible for this patients account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information"

Name of responsible party _____ Relationship to Patient _____

Mailing Address _____City _____ State _____ Zip _____

Sex: M F Age:_____ Birth date: _____ Single Married Widow Separated Divorced SS# _____

Home Phone Number: _____ Work Phone Number: _____

Occupation: _____ Employer: _____

Employer's Address: _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Policy Holders Name _____ Relationship to Patient _____ SS # _____DOB _____

Name of Employer _____ Employee Address _____ State _____

Insurance Co. _____ Group # _____ Address _____

Secondary Insurance Information

Policy Holders Name _____ Relationship to Patient _____ SS # _____DOB _____

Name of Employer _____ Employee Address _____ State _____

Insurance Co. _____ Group # _____ Address _____

Answers to the following questions are for our records only and will be considered confidential.

1. Have you or any member of your family been seen by us before? **Yes** **No**
   If yes, which family member (s)?_____
2. Date of last physical examination _____ Physician's Name _____
3. Date of last dental examination _____ Date of last dental x-rays _____
4. Previous Dentist's name _____City/State _____
5. Are you having pain or discomfort at this time? **Yes** **No**
6. Do you feel nervous about having dental treatment? **Yes** **No**
7. Have you ever had a bad experience in a dental office? **Yes** **No**
8. Is there anything you dislike about your smile? **Yes** **No**
9. Is there anything you would like to speak with the Doctor about in private? **Yes** **No**
10. Have you been a patient in the hospital during the past two years? **Yes** **No**
11. Have you been under the care of a medical doctor during the past two years? **Yes** **No**
12. Have you taken any medications or drugs in the past two years? **Yes** **No**
13. Are you taking any vitamins, herbal supplements or "cures"? **Yes** **No**
14. Have you ever had any excessive bleeding requiring special treatment? **Yes** **No**

ALLERGIES

Aspirin
Barbiturates
Codeine
Iodine
Latex
Local Anesthetic
Penicillin
Sulfa
Metals
Other: _____

MEDICATIONS

Please list medications you are currently taking:

_____

_____

_____

Pharmacy : _____

Place a mark on yes or no to indicate if you have had any of the following:

Chest Pain	**Yes**	**No**	Shortness of Breath	**Yes**	**No**	Hives or skin rash	**Yes**	**No**
Heart Failure	**Yes**	**No**	Ulcers	**Yes**	**No**	Alcoholism	**Yes**	**No**
Heart Disease or Attack	**Yes**	**No**	Mental Retardation	**Yes**	**No**	Herpes	**Yes**	**No**
Angina Pectoris	**Yes**	**No**	Emphysema	**Yes**	**No**	Glaucoma	**Yes**	**No**
Heart Problems	**Yes**	**No**	Fainting or dizzy spells	**Yes**	**No**	*Steroid Treatment	**Yes**	**No**
Liver Disease	**Yes**	**No**	Eating Disorder	**Yes**	**No**	Arthritis	**Yes**	**No**
Heart Surgery	**Yes**	**No**	Epilepsy or seizures	**Yes**	**No**	*Any type of implant	**Yes**	**No**
High Blood Pressure	**Yes**	**No**	Persistent Cough	**Yes**	**No**	Dentures or Partials	**Yes**	**No**
*Heart Murmur	**Yes**	**No**	Tuberculosis (TB)	**Yes**	**No**	Birth defects	**Yes**	**No**
*Rheumatic Fever	**Yes**	**No**	Asthma	**Yes**	**No**	HIV Positive, ARC, AIDS	**Yes**	**No**
Psychiatric treatment	**Yes**	**No**	*Congenital Heart Problems	**Yes**	**No**	Hay fever	**Yes**	**No**
Sickle Cell Disease	**Yes**	**No**	Hepatitis A (Infectious)	**Yes**	**No**	Use of tobacco products	**Yes**	**No**
Sinus trouble	**Yes**	**No**	Hepatitis B (Serum)	**Yes**	**No**	Bruise easily	**Yes**	**No**
*Artificial joints	**Yes**	**No**	Hepatitis C or other	**Yes**	**No**	Jaundice	**Yes**	**No**
Thyroid Disease	**Yes**	**No**	Heart pacemaker	**Yes**	**No**	Heart Surgery	**Yes**	**No**
Anemia	**Yes**	**No**	Stroke	**Yes**	**No**	Kidney Trouble	**Yes**	**No**
Blood transfusion	**Yes**	**No**	Drug addiction	**Yes**	**No**	Hemophilia	**Yes**	**No**
*Any type of transplant	**Yes**	**No**	Cold Sores	**Yes**	**No**	Diabetes	**Yes**	**No**
*Mitral Valve Prolapse	**Yes**	**No**	Radiation Therapy	**Yes**	**No**	Chemotherapy	**Yes**	**No**
						Cancer (type:)	**Yes**	**No**

***Antibiotic pre-medication may be required prior to your appointment.**

Have you ever experienced any of the following problems with your jaw:

Clicking	**Yes**	**No**
Pain in or around your ears ?	**Yes**	**No**
Difficulty opening or closing	**Yes**	**No**
Difficulty chewing	**Yes**	**No**
Do you have a history of trauma to your jaw?	**Yes**	**No**
Have you ever been diagnosed with TMJ/TMD?	**Yes**	**No**

Do you have currently have any problems listed below?
Please circle all that apply:

Swelling Bad Taste
Bleeding Gums Loose Teeth

Sensitive to:

Hot Cold
Biting/Pressure Sweets

Other: _____

Do you have any sores, lumps or growths in or near your mouth?	**Yes**	**No**	Problem with bad breath? (Halitosis)	**Yes**	**No**
Have you ever had difficult extraction's in the past?	**Yes**	**No**	Do you have any trouble chewing?	**Yes**	**No**
Have you ever had prolonged bleeding following extraction's?	**Yes**	**No**	Does food collect between your teeth?	**Yes**	**No**
Are there now any growths or sores in or around your mouth?	**Yes**	**No**	Have you ever had instructions in oral hygiene ?	**Yes**	**No**
Do you habitually clench or grind your teeth during the day or night?	**Yes**	**No**	Have you ever taken Redux or Pondimin (Fen Phen) ?	**Yes**	**No**

Have you ever been told you have gum problems?	**Yes**	**No**
Have you ever needed to see a periodontist ?	**Yes**	**No**
Do you now have bleeding gums or any other gum condition?	**Yes**	**No**
Is there anything related to your medical or dental history that you have not indicated above ?	**Yes**	**No**

If yes, please explain: _____

WOMEN: Are you pregnant now?	**Yes**	**No**	If yes, what is your due date? _____
Are you currently breast feeding?	**Yes**	**No**	
Are you taking oral contraceptives?	**Yes**	**No**	

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise pay able to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or guardian