

Patient Number _____ A B C

HEALTH HISTORY & REGISTRATION

Patient's Name _____ Sex: M F Birthday _____ Age _____ Today's Date _____

Home Address _____ City _____ State _____ Zip _____

Previous Address (If less than 3 Years) _____ City _____ State _____ Zip _____

Please Circle One: Single, Married, Separated, Divorced, Widowed Occupation _____ Home Phone Number _____

Your Employer _____ How Long Employed? _____ Your Soc. Sec. # _____ Work Phone _____

Are you a full-time student? Yes No If Patient is a minor, we need: Mother's Birthdate _____ Father's Birthdate _____

Name of Spouse (Parent If Minor) _____ Person Responsible for Account _____

Spouse's (Parent's) Employer _____ Spouse's Soc. Sec. # _____ Work Phone _____

Referred to us by _____

Reason for this visit _____

EMERGENCY INFORMATION
Name, Address & Telephone of
a Relative Not Living with You _____**DENTAL INSURANCE INFORMATION (Primary Carrier)**

Insured's Name _____

Insurance Co. _____

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. _____

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

MEDICAL HISTORY

YES NO

How LONG SINCE you have seen a Dentist? _____

Last COMPLETE Dental Exam, Date: _____

Last FULL MOUTH X-RAYS, Date: _____

(Machine that rotates around your head, or 16 small films.)

Are you having PROBLEMS now? YES NO

WHAT? _____

Is your present dental health POOR? YES NODo you wear DENTURES? (Partials or Full) YES NOAre you UNHAPPY with your dentures? YES NOWould you like to know more about PERMANENT REPLACEMENTS? YES NOHave you had BAD dental experiences in the past? YES NOAre you APPREHENSIVE about dental treatments? YES NOHave you had any PERIODONTAL (GUM) treatments? YES NODo your gums BLEED, or feel TENDER or IRRITATED? YES NOAre your teeth SENSITIVE to hot, cold, sweets, pressure? (circle) YES NOAre you UNHAPPY with the APPEARANCE of your teeth? YES NOAre you aware of GRINDING or CLENCHING your teeth? YES NODo you have HEADACHES, EARACHES, or NECK PAINS? YES NODo you have LOOSE, TIPPED, or SHIFTING teeth? (circle) YES NOHave you worn BRACES on your teeth? (ORTHODONTICS) YES NODo you have DISCOLORED teeth that bother you? YES NOWould you like your smile to LOOK BETTER or DIFFERENT? YES NODo you have problems with teeth fillings BREAKING? YES NODo you REGULARLY use DENTAL FLOSS? YES NOWould you like us to help you learn proper methods of Home Care, so you can stop dental problems in your mouth? YES NO

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 # _____

Do you have any CURRENT HEALTH PROBLEMS? YES NOAre you under a PHYSICIAN'S CARE now? YES NO

For What? _____

Are you currently taking any medication? YES NO

If yes, what? _____

Are you pregnant? YES NODo you smoke? YES NO

FAMILY PHYSICIAN: _____ PHONE NO. _____

Circle any of the following which you have had or have at present:

Heart Failure	A.I.D.S.	Bruise Easily
Heart Disease or Attack	Hepatitis A (infectious)	Emphysema
Angina Pectoris	Hepatitis B (serum)	Tuberculosis (TB)
High Blood Pressure	Liver Disease	Asthma
Heart Murmur	Yellow Jaundice	Hay Fever
Rheumatic Fever	Blood Transfusion	Sinus Trouble
Congenital Heart Lesions	Drug Addiction	Allergies or Hives
Scarlet Fever	Hemophilia	Diabetes
Artificial Heart Valve	Fever Blisters	Thyroid Disease
Heart Pacemaker	Epilepsy or Seizures	X-ray or Cobalt Treatment
Heart Surgery	Fainting or Dizzy Spells	Arthritis
Artificial Joints (Hip, Knee)	Nervousness	Rheumatism
Anemia	Psychiatric Treatment	Cortisone Medicine
Stroke	Sickle Cell Disease	Pain in Jaw Joints
Kidney Trouble	Glaucoma	Alcoholism
Ulcers	Chemotherapy (Cancer, Leukemia)	Bleeding Problems
Cosmetic Surgery	Venereal Disease (Syphilis, Gonorrhea, etc.)	

Are you allergic or have you reacted adversely to any of the following medications?

Aspirin _____ Percodan _____ Erythromycin _____

Darvon _____ Local Anesthetic _____ Valium _____

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?

PATIENT Signature (Parent of Child) _____

Date: _____ DENTIST Signature _____