

REGISTRATION FORM / MEDICAL-DENTAL HISTORY

PATIENT REGISTRATION FOR: _____

Residence Address	
Telephone	Referred By
Other Family Members in the Practice	Preferred Time for Appointments
SSN - -	DOB / /
Marital Status S M D W	Spouse's Name
If Minor, Name of Guardian	Address & Telephone
Person Responsible for Fee (if other than patient)	Relationship to Patient
Billing Address (if different from above)	
Occupation	Will you receive calls at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer's Name & Telephone	
EMERGENCY NOTIFICATION Name & Telephone	



INSURANCE INFORMATION		
	Primary Carrier	Secondary Carrier
Name of Insurance Company		
Address		
Telephone		
Subscriber's Name/ Relationship to Patient	/	/
Name of Group Policyholder or Union		
Group Policy # / Individual Policy #	/	/
Effective Date / Time Limit for Claims	/	/
Pre Estimate Required	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Method of Payment	<input type="checkbox"/> UCR <input type="checkbox"/> Schedule of Payments <input type="checkbox"/> Other	<input type="checkbox"/> UCR <input type="checkbox"/> Schedule of Payments <input type="checkbox"/> Other
Coinsurance	Company _____ % Patient _____ %	Company _____ % Patient _____ %
Deductible	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Annual \$ _____ <input type="checkbox"/> Lifetime \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Annual \$ _____ <input type="checkbox"/> Lifetime \$ _____
Plan Covers Orthodontics	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other		
If credit card payment is accepted:	Name of Card:	
	Card #	Expiration Date

Medical History**INSTRUCTIONS**

"I understand that honest answers to the questions stated below are important to the provision of my dental care, and that I will answer them to the best of my ability. I have been informed that if I am uncertain about the question or how the question related to my health status, I must discuss the problem with the doctor or a member of the office staff. I understand that all questions must be answered. I have been assured that the information I provide will not be released without my express permission."

Patient's Initials _____ Dentist's Initials _____

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office – to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided.

All questions must be answered and written in ink.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

1. Name, address & phone # of your physician _____

2. Date of last visit to your doctor _____ Purpose of visit _____

3. Do you suffer from any disability? _____ If yes, describe _____

4. Have you ever, or do you now take illegal drugs? _____ If yes, what drugs, and when taken? _____

Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.

5. Do you have AIDS, or are you HIV-positive? _____ If yes, describe and provide current status. _____

6. Do you now have, or have you ever had a venereal disease? _____ If yes, describe. _____

7. Have you ever had, or do you now have hepatitis? _____ If yes, describe. _____

8. For females: Are you pregnant? _____ If yes, when are you due? _____

9. For females: Are you taking birth control pills? _____

Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.

10. List all medications you are now taking or have taken previously on a regular basis, describe the strength and purpose for each.

Note: There are many drugs and medications when mixed with other drugs and/or medications may cause complications, some of which may result in dangerous health problems. Information about your current use of drugs and medications is essential.

11. Have you ever had an allergic reaction to medication? _____ If yes, describe. _____

12. Have you lost weight recently? _____ If yes, describe. _____

Have You Ever Had Or Been Treated For:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? _____

14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? _____

15. Stomach or intestinal disease? _____

Medical History [continued]

16. Abnormal blood pressure, excessive bleeding, or anemia? _____
17. Breathing problems, asthma, tuberculosis, or hay fever? _____
18. Cancer, X-ray treatments, chemotherapy, or IV bisphosphonate (i.e. Zometa or Aredia) treatment? _____
19. Diabetes? _____
20. Kidney problems or renal dialysis? _____
21. A stroke, convulsions, or fainting spells? _____
22. Tumors or growths? _____
23. Arthritis or rheumatism? _____
24. Have you ever had a major operation? _____ If yes, describe. _____
25. Have you ever had a serious injury to your head or neck? _____ If yes, describe. _____
26. Are you on a special diet? _____ If yes, for what reason and describe. _____
27. Do you smoke? _____ If yes, describe type and quantity. _____
28. Have you consulted or been treated by a psychiatrist, psychologist, or counselor? _____ If yes, when and describe. _____
29. Do you consume any alcoholic beverages? If yes, how much and how often? _____
30. Are there any other problems about your health of which you are aware? _____
31. For children under 10 years old: Was the child born by Cesarean Section? _____
32. Females: Are you currently taking any bisphosphonate medication? _____
33. Have you had any prosthetic joint replacement? _____
34. Are you allergic to latex? _____
35. Do you ever notice that your feet and/or ankles are swollen? _____
36. Are you aware of any swollen glands in your neck? _____

Dental History

1. Name of previous dentist _____ Date of your last visit _____
2. Reason for your last visit (or series of visits) _____
3. Do you have any of your X-rays or dental records? _____
4. Chief dental complaint if any? _____
- In respect to any previous dental treatment have you:**
5. Ever fainted? _____
6. Had an allergic reaction? _____
7. Had abnormal bleeding? _____
8. Any other complications during or following dental treatment? _____ If yes, describe. _____
9. Do your gums bleed on brushing or eating? _____
10. Does food catch between your teeth? _____
11. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? _____

Dental History [continued]

- 12. Are any of your teeth sensitive to heat, cold, or pressure? _____
- 13. Do you grind your teeth or clench your jaws? _____
- 14. Do you have pain or clicking in the jaw joint in front of your ear? _____

- 15. Have your jaw muscles ever been sore? _____ If yes, describe. _____

- 16. Are there any sores or growths in your mouth? _____

- 17. Do any of your teeth ache? _____
- 18. Do you have any other dental complaint? _____

To the best of my knowledge, the foregoing questions have been accurately answered.

NOTE: A change in your health status should be reported to the office immediately.

"I understand that should there be a change in my health during my dental treatment, I am to inform the dentist at the earliest possible time."

Patient's Initials _____ Dentist's Initials _____

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or health practitioners.

Person completing the form: _____ Signature _____

Witness _____ Print Name _____

If other than patient, indicate relationship _____ Date _____

<p>Dentist's History Review & Significant Findings: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Signature: Dr. _____ Date: _____</p>

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