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
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?	☐	☐
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?	☐	☐
Have you had BAD dental experiences in the past?	☐	☐
Are you APPREHENSIVE about dental treatments?	☐	☐
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?	☐	☐
Do you have LOOSE, TIPPED, or SHIFTING teeth? (circle)	☐	☐
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 have problems with teeth fillings BREAKING?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Would you like us to help you learn proper methods of Home Care, so you can stop dental problems in your mouth?	☐	☐
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?		
Are you currently taking any medication?	☐	☐
If yes, what?		
Are you pregnant?	☐	☐
Do you smoke?	☐	☐
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?

_____

_____

_____

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnosis aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any-overdue balance. I also assign all insurance benefits to the Doctor.

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____