# REGISTRATION AND HEALTH HISTORY

| | | | | | | |
|---|---|---|---|---|---|---|
| Name | Single | Married | Long-Term Partner | Divorced | Separated | Widowed |
| Social Security number | Birthdate | Home phone | Business phone | | | |
| Address | City | State | Zip | | | |
| Employed by | City | State | Zip | | | |
| Present position | How long held | Your driver license no. | State | | | |
| Spouse/partner's name | | | | | | |
| Spouse/partner's Social Security number | Spouse/partner's birthdate | Business phone | | | | |
| Spouse/partner employed by | City | State | Zip | | | |
| Present position | How long held | Spouse/partner's driver license no. | State | | | |
| Referred by | Address | | | | | |
| Who will pay for this account? | Credit card name | No. Expiration date | | | | |
| Name of your dental insurance company | | | | | | |
| Name of your spouse/partner's dental insurance company | | | | | | |

***It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your written permission.***

## YOUR DENTAL HISTORY

**Are** you having any discomfort at this time _____ **How** long since you have been to a dentist _____

**Did** you have X-Rays _____ **How** often did you visit a dentist before then _____ **Have** you lost any teeth _____ Why _____

**Any** complications with extractions _____

**Have** they ever been replaced by: (1) A Fixed Bridge _____ (2) Removable Partial _____ (3) Denture _____

How many of (1) (2) (3) _____

**Are** your teeth sensitive to heat _____ to cold _____ to sweets _____ to sour _____ **Have** you had your teeth straightened _____ When _____ **How** often do you brush your teeth _____ When _____

**How** _____

_____

**How** long do you use a toothbrush before replacing it _____

**Do** you use dental floss _____ How often _____

Between-the-teeth stimulator _____ Water jet _____

**Do** you have bleeding gums _____ When _____

_____

**Do** you eat between meals _____ **Do** you brush teeth after snacks _____ **Does** food wedge between your teeth _____ Where _____ **Do** you grind or clench your teeth _____ When _____

**Have** you ever had gum treatments _____ When _____

**Do** you feel you have bad breath at times _____

**Unpleasant** taste in mouth _____ **Any** pain in or around your ears _____ **Do** you hear popping, clicking or snapping noises when you chew _____ **Do** you have any nasal obstruction _____ **Are** you aware of any swelling or lump in your mouth _____



*Other side, please*

**Do** you now have or have you had any of the following habits: Thumbsucking _____ Fingersucking _____

Cheek or tongue chewing _____ Chewing on Pencils _____ Pens _____ Lip _____ Fingernails _____

Tobacco use _____ Alcohol use _____

**Do** you have any fear of having dentistry done _____

If yes, why _____

**How** do you feel about your teeth _____

**How** do you feel about your dentures _____

**Do** you want to avoid the dental discomfort you may have experienced in the past _____

**Do** you want to avoid dentures _____

**Do** you want to have a pleasant breath _____

**Do** you want to know how you can keep the natural teeth you still have _____

**If** you have children, do you want to learn how they may keep their natural teeth for a lifetime without discomfort _____

## MEDICAL HISTORY

Physician's name _____ Date of last physical exam _____

Birthdate _____ Age _____

Do you have or have you had any of the following. Please indicate with Check mark (✔)

___ Any heart problems
___ High blood pressure
___ Low blood pressure
___ Circulatory problems
___ Nervous problems
___ Radiation treatments
___ Excessive bleeding
___ HIV/AIDS
___ Allergies to anesthetics

___ Allergies to medicines or drugs
___ Allergies to:
_____
_____
_____
___ Anemia
___ Arthritis
___ Asthma

___ Eating Disorder
___ Diabetes
___ Hepatitis
___ Herpes
___ Malignancies
___ Measles
___ Mumps
___ Psychiatric care
___ Rheumatic Fever

___ Scarlet Fever
___ Sinus Problems
___ Stroke
___ Typhoid Fever
___ Tonsillitis
___ Tuberculosis
___ Ulcer
___ Venereal Disease
___ Other

Are you pregnant _____ Blood Pressure: S ____ /D ____ / ____

***Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.***

_____

_____

_____

_____

_____

_____

_____

_____

Date _____ Your signature _____