HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

NAME Last _____ First _____ M.I. _____

SEX: M F DOB _____ SSN _____

RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt.# _____ City _____ State _____ Zip _____

PHONE: Home _____ Work _____ Cell _____

EMAIL ADDRESS(ES) _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____

If Patient is a Minor, give Parent / Guardian's Name & Relationship _____

How did you hear about our office? _____

Reason for today's visit _____

SPOUSE / SIGNIFICANT OTHER

Name _____

Employer _____

Work # _____ Cell # _____

EMERGENCY CONTACT INFORMATION:

Name _____

Home Phone _____

Work # _____ Cell # _____

PRIMARY DENTAL INSURANCE

Cardholder's Name _____

Cardholder's Address _____

Relation to patient _____

Cardholder's DOB _____

Cardholder's Employer _____

Cardholder's ID Number / SSN _____

Group Number _____

Insurance Co. Name _____

Claims Address _____

_____

Max. Annual Benefit $_____ Used to date $_____

SECONDARY DENTAL INSURANCE (if applicable)

Cardholder's Name _____

Cardholder's Address _____

Relation to patient _____

Cardholder's DOB _____

Cardholder's Employer _____

Cardholder's ID Number / SSN _____

Group Number _____

Insurance Co. Name _____

Claims Address _____

_____

Max. Annual Benefit $_____ Used to date $_____

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____

SIGNATURE OF PATIENT (or parent / guardian if patient is a minor) Date

*It is important that the doctors and hygienists know about your Medical and Dental History. These facts can have a **direct bearing** on your dental health. This information is strictly confidential and will not be released to anyone, except as outlined in our privacy practices. Thank you for taking the time to completely fill out this questionnaire.*

DENTAL HISTORY

How long has it been since you have seen a dentist? _____

Date of last:
Panoramic / Full Mouth X-rays _____
Bitewing X-rays _____
Cleaning _____
Exam _____

Name of previous dentist: _____

Phone # _____

Are you having any problems now? Y / N

If yes, what? _____

	YES	NO
Have you had periodontal (gum) treatments?	____	____
Do you regularly use dental floss?	____	____
Are your teeth sensitive to: **Hot / Cold / Sweets / Pressure (circle all that apply)**		
Are you aware of grinding or clenching?	____	____
Do you have frequent headaches, earaches, or neck pains?	____	____
Have you ever had braces (orthodontics)?	____	____
Do you have discolored teeth that bother you?	____	____
Would you like your smile to look better or different?	____	____

Please rank the following concerns in the order in which they would prevent you from having dental treatment:
(using 1 for the most likely and 3 for the least likely)

Fear of pain # _____
Cost of treatment # _____
Missing work time # _____

MEDICAL HISTORY

Do you have any current health problems? Y / N

Are you under a physician's care now? Y / N

If yes, for what? _____

Physician's Name and # _____

List current medications & reasons for taking them.

_____

_____

Do you need antibiotics prior to your dental visits? Y / N

Pharmacy Name & Number: _____

WOMEN: Are you pregnant? Y / N

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	High Blood Pressure
Bruise Easily	AIDS / HIV Positive
Hepatitis A (infectious)	Tuberculosis (TB)
Hepatitis B (serum)	Asthma
Hepatitis C	Drug Addiction
Congenital Heart Lesions	Sinus Trouble
Artificial Heart Valve	Hemophilia / VWD
Diabetes (Type 1 or 2 ?)	Heart Pacemaker
Fever Blisters (cold sores)	Heart Surgery
Epilepsy / Seizures	Alcoholism
Artificial Joints (hip, knee)	Pain in jaw joints
Tobacco use	Anxiety Attacks
Radiation Treatment	Chemotherapy

Do you take medication for osteoporosis (Fosamax, Boniva, etc.)?

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING?

Aspirin	Local Anesthetic	Erythromycin
Codeine	Penicillin / Amoxicillin	Latex

Are you aware of being allergic to any other foods, medications, or substances? _____ If yes, please list:

_____

Is there any other information (medical, dental, or otherwise) that you feel the doctor should know about?

_____

_____

All of the above information is true and accurate to the best of my knowledge. _____ **Signature** _____ **Date**