

Patient Number _____

HEALTH HISTORY & REGISTRATION**PATIENT INFORMATION**

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

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

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

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EMAIL _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSENAME _____
LAST FIRST MIDDLEEMPLOYER _____ OCCUPATION _____ ()
NO. YEARS EMPLOYED

SOC. SEC. # _____ BIRTHDATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY, STATE _____

HOME PH. _____ CELL PH. _____

WORH PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ E-MAIL _____

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. _____ E-MAIL _____

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		MEDICAL HISTORY	
	YES	NO	
How long since you have seen a dentist?			Do you have any current health problems? <input type="checkbox"/> YES <input type="checkbox"/> NO
Last complete dental exam, date:			Are you under a physician's care now? <input type="checkbox"/> YES <input type="checkbox"/> NO
Last full mouth x-rays, date: (16 small films or panoramic)			For what?
Are you having problems now? <input type="checkbox"/> YES <input type="checkbox"/> NO			What medications are you currently taking?
What?			Have you ever taken fen-phen/redux? <input type="checkbox"/> YES <input type="checkbox"/> NO
Is your present dental health poor? <input type="checkbox"/> YES <input type="checkbox"/> NO			Are you pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you wear dentures? (partials or full) <input type="checkbox"/> YES <input type="checkbox"/> NO			Do you use cigars/cigarettes, pipe or chewing tobacco? (circle) <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you unhappy with your dentures? <input type="checkbox"/> YES <input type="checkbox"/> NO			PLEASE <input checked="" type="checkbox"/> YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:
Would you like to know more about permanent replacement? <input type="checkbox"/> YES <input type="checkbox"/> NO			AIDS/HIV Pos. <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you apprehensive about dental treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO			Anaphylaxis <input type="checkbox"/> YES <input type="checkbox"/> NO
Have you had any periodontal (gum) treatments? <input type="checkbox"/> YES <input type="checkbox"/> NO			Anemia <input type="checkbox"/> YES <input type="checkbox"/> NO
Do your gums bleed, or feel tender or irritated? <input type="checkbox"/> YES <input type="checkbox"/> NO			Arthritis (Rheumatism) <input type="checkbox"/> YES <input type="checkbox"/> NO
Are your teeth sensitive to hot, cold, sweets, pressure? (circle) <input type="checkbox"/> YES <input type="checkbox"/> NO			Artificial Heart Valves <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you unhappy with the appearance of your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO			Artificial joints <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you aware of grinding or clenching your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO			Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have headaches, earaches, or neck pains? <input type="checkbox"/> YES <input type="checkbox"/> NO			Atopic (Allergy Prone) <input type="checkbox"/> YES <input type="checkbox"/> NO
Have you worn braces on your teeth (orthodontics)? <input type="checkbox"/> YES <input type="checkbox"/> NO			Back Problems <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have discolored teeth that bother you? <input type="checkbox"/> YES <input type="checkbox"/> NO			Blood Disease <input type="checkbox"/> YES <input type="checkbox"/> NO
Would you like your smile to look better or different? <input type="checkbox"/> YES <input type="checkbox"/> NO			Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you regularly use dental floss? <input type="checkbox"/> YES <input type="checkbox"/> NO			Chemical dependency <input type="checkbox"/> YES <input type="checkbox"/> NO
ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?			Chemotherapy <input type="checkbox"/> YES <input type="checkbox"/> NO
Aspirin _____ Local Anesthetic _____			Circulatory problems <input type="checkbox"/> YES <input type="checkbox"/> NO
Latex (balloons, gloves, etc.) _____ Erythromycin _____			Cortisone treatments <input type="checkbox"/> YES <input type="checkbox"/> NO
Nitrous Oxide _____ Codeine _____			Cough (persistent) <input type="checkbox"/> YES <input type="checkbox"/> NO
Penicillin _____			Cough up blood <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you aware of being allergic to any other medications or substances? If yes, list: _____			Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO
			Epilepsy <input type="checkbox"/> YES <input type="checkbox"/> NO
			Fainting <input type="checkbox"/> YES <input type="checkbox"/> NO
			Food allergies <input type="checkbox"/> YES <input type="checkbox"/> NO
			Glaucoma <input type="checkbox"/> YES <input type="checkbox"/> NO
			Headaches <input type="checkbox"/> YES <input type="checkbox"/> NO
			Heart murmur <input type="checkbox"/> YES <input type="checkbox"/> NO
			Heart problems (please describe) <input type="checkbox"/> YES <input type="checkbox"/> NO
			Hemophilia (Abnormal bleeding) <input type="checkbox"/> YES <input type="checkbox"/> NO
			Herpes <input type="checkbox"/> YES <input type="checkbox"/> NO
			Hepatitis <input type="checkbox"/> YES <input type="checkbox"/> NO
			High blood pressure <input type="checkbox"/> YES <input type="checkbox"/> NO
			Jaw pain <input type="checkbox"/> YES <input type="checkbox"/> NO
			Kidney disease or malfunction <input type="checkbox"/> YES <input type="checkbox"/> NO
			Liver disease <input type="checkbox"/> YES <input type="checkbox"/> NO
			Material allergies (latex, wool, metal, chemicals) <input type="checkbox"/> YES <input type="checkbox"/> NO
			Mitral valve prolapse <input type="checkbox"/> YES <input type="checkbox"/> NO
			Nervous problems <input type="checkbox"/> YES <input type="checkbox"/> NO
			Pacemaker/heart surgery <input type="checkbox"/> YES <input type="checkbox"/> NO
			Psychiatric care <input type="checkbox"/> YES <input type="checkbox"/> NO
			Rapid weight gain/loss <input type="checkbox"/> YES <input type="checkbox"/> NO
			Radiation treatment <input type="checkbox"/> YES <input type="checkbox"/> NO
			Respiratory disease <input type="checkbox"/> YES <input type="checkbox"/> NO
			Rheumatic/scarlet fever <input type="checkbox"/> YES <input type="checkbox"/> NO
			Shingles <input type="checkbox"/> YES <input type="checkbox"/> NO
			Shortness of breath <input type="checkbox"/> YES <input type="checkbox"/> NO
			Skin rash <input type="checkbox"/> YES <input type="checkbox"/> NO
			Spina Bifida <input type="checkbox"/> YES <input type="checkbox"/> NO
			Stroke <input type="checkbox"/> YES <input type="checkbox"/> NO
			Surgical implant <input type="checkbox"/> YES <input type="checkbox"/> NO
			Swelling of feet or ankles <input type="checkbox"/> YES <input type="checkbox"/> NO
			Thyroid disease or malfunction <input type="checkbox"/> YES <input type="checkbox"/> NO
			Tobacco habit <input type="checkbox"/> YES <input type="checkbox"/> NO
			Tonsillitis <input type="checkbox"/> YES <input type="checkbox"/> NO
			Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO
			Ulcer/Colitis <input type="checkbox"/> YES <input type="checkbox"/> NO
			Venereal disease <input type="checkbox"/> YES <input type="checkbox"/> NO
			FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____
			<i>Is there any other Medical or Dental information that you feel we should know about?</i>

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