HEALTH HISTORY AND REGISTRATION

Patient's Name_____ Sex: M F Birthdate_____Age_____
Home
Address_____City_____State_____Zip_____
E-mail
Address_____Occupation_____
Home Phone
Number_____Mobile_____Work_____
Single,Married,Separated, Legal Partner, Divorced, Widowed/Occupation_____
Your Employer_____Your SS#_____
Full Time Student? Yes___ No___
Birthdate_____ If a minor give Father's Birthdate_____Mother's Birthdate_____
Name of Spouse, Partner, or Parent_____
Their Employer_____SS#_____Work#_____
Phone_____
Preferred Form of Communication (circle): cell home # work # email
Person Responsible for Account_____
Referred By_____Emergency Info.- Name_____
Address_____
_____
Reason for Visit_____ Phone #_____

DENTAL INSURANCE-PRIMARY
Insured _____
Insurance Co. _____
Address _____
Insured's Employer _____
Insured's SS# _____
Group# _____ Local# _____

DENTAL INSURANCE SECONDARY
Insured _____
Insurance Co. _____
Address _____
Insured's Employer _____
Insured's SS# _____
Group #_____ Local#_____

MEDICAL INSURANCE
Patient (Insured) _____
Subscriber's Name _____
Subscriber's DOB_____
Subscriber's SS# _____
Insurance Co._____
Co. Address _____
_____
Subscriber Employer_____
Group# _____
ID# _____

MEDICAL HISTORY

TELL US ABOUT YOUR HEALTH?_____
_____
_____

DO YOU HAVE ANY PINS OR SCREWS IN YOUR JOINTS, LIMBS OR SKULL?_____
WHERE DO YOU HAVE PINS OR SCREWS?_____

FAMILY PHYSICIAN_____

PHONE#_____

NAME OF PREVIOUS DENTIST_____
ADRESS_____
PHONE#_____

Are you currently taking any medication? Yes_____No____ If yes, what?

_____

For Women: are you Pregnant, trying to get pregnant, or on birth control? (circle)

Circle any of the following which you have had or have at present:

Heart Failure	Artificial Heart Valve Heart	Cosmetic Surgery	Hemophilia	Chemotherapy	Allergies/Hives
Heart Disease	Attack/Pacemaker	AIDS	Fever Blisters	Cancer	Diabetes
AnginaPectoris	Heart Surgery	Hepatitis A	Epilepsy/Seizures	Venereal Disease	Thyroid Disease
High Blood Pressure	Artificial Joints	Hepatitis B	Fainting/Dizzy Spells	X-ray/Cobalt Treatment	Arthritis
Heart Murmur	Anemia	Liver Disease	Nervousness	Bruise easily	Rheumatism
Rheumatic Fever	Stroke	Yellow Jaundice	Emphysema	Rheumatism	Psychiatric Treatment
Congenital Heart Lesions	Kidney Trouble	Blood Transfusion	Sickle Cell Disease	Tuberculosis	Cortisone Med
Scarlet Fever	Ulcers	Drug Addiction	Glaucoma	Asthma	Pain In Jaw Joint

Are you allergic or have you reacted adversely to any of the following?
Aspirin Nitrous Oxide Local Anesthetic Erythromycin Penicillin Valium Darvon Percodan Codeine

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

DENTAL HISTORY

How long since you have seen a Dentist?_____
Last Complete Dental Exam Date:_____
Last Full Mouth X-Rays, Date:_____
Are you having problems now?_____
What?_____
_____
What made you choose our office? _____
_____
_____
Tell us about your most memorable dental experience?_____
_____
_____
_____
Additional Info that you would like to share with us: _____
_____
_____
_____
_____

FAMILY HISTORY

Has any family member or Immediate relative have or had the following:

Early loss of teeth	Over or underweight
Periodontal Disease	Cancer
High or low blood pressure	Stomach trouble
Bleeding Tendency	Ulcers
Stroke	Lung Disease
Heart Disease	Arthritis
Diabetes	Nervousness

_____

Do you have headaches? past_____present___
Do you have pain in jaw joints? past___present___
Do you have noises in jaw joints? past___present___
Do you have neck pain? past___present___
Do you have broken/sensitive teeth? past__present__

Do you dose off: while reading_____
watching TV_____
sitting inactive_____
in a public place_____
Has anyone noticed that you stopped breathing during your sleep?_____

CONSENT:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic 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 the time services are rendered unless financial arrangements have been made.

PATIENT Signature (Parent of child)_____ DATE: _____ DENTIST Signature_____