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____________