

HEALTH HISTORY & REGISTRATION

WELCOME TO OUR OFFICE! We will do our best to make your appointment as convenient and pleasant as possible. It is important to know 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 without your consent.

PATIENT INFORMATION

Patient's Name _____ Sex: M F Birthdate _____ Age _____ Today's Date _____
Home Address _____ City _____ State _____ Zip _____
Phone (Home) _____ (Work) _____ (Cell) _____
Please indicate one: Single _____ Married _____ Divorced _____ Widowed _____, Soc. Sec # _____
Email Address: _____

SPOUSE/PARENT INFORMATION

Name of Spouse _____ Spouse's Birthdate _____ Work Phone _____
Name of Parent (If Minor) _____ Work Phone _____ May we contact you at work? Yes No
Address (If Different) _____ City _____ State _____ Zip _____
Are you a full time student? No Yes If Patient is a minor we need: Mother's DOB _____ Father's DOB _____

ACCOUNT INFORMATION

Person responsible for account _____ Relationship _____
Phone (Home) _____ (Work) _____ Soc. Sec. # _____
Home Address _____ City _____ State _____ Zip _____

EMPLOYER INFORMATION

Employer Name _____
Occupation _____ How long employed _____

EMERGENCY INFORMATION

Name _____ Phone _____
Address _____ City _____ State _____ Zip _____

Reason for this visit _____

Referred to us by _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____
Insured's Employer _____
Insured's Soc. Sec # _____
Insurance Company _____

SECONDARY COVERAGE

Insured's Name _____
Insured's Employer _____
Insured's Soc. Sec # _____
Insurance Company _____

CONSENT:

The undersigned hereby authorizes the Doctor to take X-rays, study model, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents and injections embody a certain risk.

RESPONSIBILITY OF ACCOUNT:

I understand that responsibility for payment for Dental Services provided in this office for my self or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

PATIENT Signature (Parent if Minor) _____ Date _____

Sign here to authorize insurance payment, _____

Signature on File

MEDICAL HEALTH FORM

NO

YES

Have you been instructed by a physician or dentist to take antibiotics before dental treatment? _____

Are you under any medical treatment now? _____

If so, for what? _____

Have you been hospitalized within the last 5 years? _____

If so, for what? _____

Have you had any major operations? _____

If so, for what? _____

Are you taking any medications? (including over-the-counter & herbal) _____

Provide name of drug/ its purpose: _____

Physician's Name _____ Phone # _____

Date of Last Physical Exam _____ Last Blood Pressure Reading _____/_____

Are you allergic to any medications? Yes [] No []

If "Yes", please circle or list: Penicillin Codeine Latex Local Anesthetics _____

Do you have, or have you ever had:

Table with 6 columns: No, Yes, No, Yes, No, Yes. Rows list various medical conditions such as Artificial heart valve/Prosthesis, Heart ailment, High Blood Pressure, Heart Attack, etc.

Name of previous Dentist? _____ Your last visit to the dentist? _____

- Have you had any unusual difficulties with any previous dental treatment? YES NO
Are you apprehensive (nervous) about your dental treatment? YES NO
If yes, have you had: Nitrous Oxide (Laughing gas), prior to treatment? YES NO
Are you satisfied with your past dentistry? YES NO
Are your teeth sensitive to: hot, cold, sweets, pressure? YES NO
Are you unhappy with the appearance of your teeth? YES NO
Are you aware of grinding or clenching your teeth? YES NO
Have you had periodontal (gum) treatments or seen a PERIODONTIST? YES NO
Do your gums bleed when you brush and floss your teeth? YES NO
Have you ever had pain or noises in your jaw joint / TMJ? YES NO
Do you, or have you ever smoked or used tobacco? YES NO If so, type: _____ How long _____
Have you worn braces on your teeth: ORTHODONTICS? YES NO If so, when: _____
Do you have skin reactions to jewelry? YES NO
Do you currently wear a retainer, nightguard or partial? YES NO
Is there anything that you prefer to talk to the Doctor in private about? YES NO

Date: _____ Patient Signature (Parent of Child) _____ Dentist Signature _____