

PATIENT REGISTRATION AND MEDICAL/DENTAL HISTORY

Medical Alert

So that we may provide you with the best possible care, please complete both sides of this medical/dental history form.

(PLEASE PRINT)

Date _____

Patient Name _____

Last
First
Middle Initial
Name Called By

Address _____

City _____ State _____ Zip _____ Tel. _____ Social Security # _____

Sex: Male Female Age _____ Birthday ____/____/____ Single Married Widowed Separated Divorced

Employed By _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____ Tel. _____ Ext. _____

Spouses Name _____ Birthday ____/____/____ Employed By _____

Business Address _____

City _____ State _____ Zip _____ Tel. _____ Social Security # _____

Who is responsible for this account? _____ Relationship to Patient _____

Dental Insurance Primary Carrier		
Insured's Name	Social Security #	
Insurance Company		
Address		
Group Number	ID Number	Birthdate
Insured's Employer		

Dental Insurance Secondary Carrier		
Insured's Name	Social Security #	
Insurance Company		
Address		
Group Number	ID Number	Birthdate
Insured's Employer		

In case of emergency, who should be notified? _____ Tel. _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Address _____ Tel. _____

Please check the box of any condition you may have had.

<input type="checkbox"/> Heart Disease or Attack	<input type="checkbox"/> Hepatitis, Jaundice or Liver Disease	<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> "A.I.D.S."/ HIV Positive or Other	<input type="checkbox"/> Special Diet
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Swollen Neck Glands
<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Stroke	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Respiratory Problem	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Headaches	<input type="checkbox"/> General Allergies	<input type="checkbox"/> Kidney Problem	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Cancer, Leukemia	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Ulcer
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Chronic Diarrhea	<input type="checkbox"/> Back Problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Allergies to Anesthetics	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Allergy to Latex	<input type="checkbox"/> Allergy to Colored Dyes	<input type="checkbox"/> Blood Transfusion

Patient Name

DENTAL HISTORY

What is the reason for your visit today? _____

Is there anything about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

Date of Last: **Dental Visit** _____ **Dental Cleaning** _____ **Full Mouth X-Rays** _____ **Bitewing X-rays** _____

What treatment was done at your last dental visit? _____

Previous Dentists Name _____ Telephone _____

Address _____

City _____ State _____ Zip Code _____

How often do you have dental examinations? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick etc.) _____

Do you have any dental problems now? Yes No If yes, please describe _____

Circle "yes" or "no" to each item

Do You:	Are any of your teeth sensitive to:	Have you experienced:
Clench or grind your teeth while awake or asleep? Yes No	Hot or cold Yes No	Clicking or popping of the jaw? Yes No
Bite your lips or cheeks regularly? Yes No	Sweet Yes No	Pain? (joint, ear, side, or face) Yes No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No	Biting or chewing Yes No	Difficulty in opening or closing the mouth? Yes No
Mouth breathe while awake or asleep? Yes No	Have you noticed any mouth odors or bad tastes? Yes No	Headaches, neckaches or shoulder aches? Yes No
Have tired jaws, especially in the morning? Yes No	Do you frequently get cold sores, blisters or any other oral lesions? Yes No	Sore muscles (neck, shoulders)? Yes No
Smoke/chew tobacco? Yes No	Do your gums bleed or hurt? Yes No	Are you satisfied with your teeth's appearance? Yes No
How much? _____	Have your parents experienced gum disease or tooth loss? Yes No	Would you like to keep all of your teeth all of your life? Yes No
Have you ever had:	Have you noticed any loose teeth or a change in your bite? Yes No	Do you feel nervous about having dental treatment? Yes No
Orthodontic treatment? Yes No	Do you have difficulty in chewing on either side of the mouth? Yes No	If yes, what is your biggest concern? _____
Oral Surgery? Yes No	Does food tend to be caught in between your teeth? Yes No	Have you ever had an upsetting dental experience? Yes No
Periodontal treatment? Yes No	If yes, where? _____	If yes, please describe _____
Your teeth ground or the bite adjusted? Yes No		
A bite plate or mouth guard? Yes No		
A serious injury to the head? Yes No		
If yes, please describe, including cause. _____		

Do you have any drug allergies or have you ever had an adverse reaction to any medication or substance? Yes No

If yes, list _____

Have you ever responded adversely to medical or dental treatment? Yes No

Are you taking any medications at this time? Yes No If yes, what _____

Are you under the care of a physician? Yes No If yes, for what condition _____

Women - Are you: Pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

Is there anything else we should know about your medical history? _____

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing, and processing of insurance for benefits for which I am entitled.

I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if minor _____ Date _____