

REGISTRATION HISTORY

Date _____ Age _____ Birthday _____
Patient's Name _____ Single _____
Name of Spouse _____ Married _____
If A Child, Parent's Name _____ Widowed _____
Mailing Address _____ Divorced _____
Street Address _____ Separated _____
City _____ State _____ Zip _____
Home Phone _____
Patient Employed By _____ Phone _____
Business Address _____
Present Position _____ How Long Held _____
Spouse Employed By _____ Phone _____
Business Address _____
Present Position _____ How Long Held _____
In case of emergency, whom should be notified _____
WHO WILL PAY THIS ACCOUNT _____
Social Security # _____ Spouse's Social Security # _____
Do you have insurance that may cover any part of our professional services?
Yes _____ No _____
If so, Name of the Company _____
Subscriber SSN _____ Place of Employment _____
Subscriber's Birthdate _____
Whom May We Thank Referring You? _____

Dental History

1. What are your reasons for seeking dental care? _____
2. Are you dissatisfied with the appearance of your teeth? Yes No
3. Have you ever experienced an unusual reaction to a dental anesthetic? Yes No
4. Do you have difficulty chewing food? Yes No
5. Do you have sensitive or aching teeth? Yes No
6. Do you have sore or bleeding gums? Yes No
7. Do you ever have sores in the mouth or on the lips?
If yes, are they present longer than 2-3 weeks? Yes No
8. Have you ever had any injury to your face or jaws? Yes No
9. Do you have sinus trouble? Yes No
10. Do you clench or grind your teeth? Yes No
11. Have you had braces, root canals, or gum surgery? Yes No

MEDICAL HISTORY

12. Are you presently in good health? Yes No
13. Have you been examined by a physician within the last 5 years? Yes No
If so, for what reason? _____

14. Are you being treated by a physician for any condition at this time? Yes No
If so, explain _____

15. Have you ever been seriously ill, been hospitalized, or had a surgical operation? Yes No
If so, explain? _____

16. Are you taking any prescription or non-prescription medications (Any form or pills, tablets, or syrups) now or have you within the past six (6) weeks? Yes No
If so, what? _____

17. Do you have or have you ever had?

Rheumatic Fever	Yes	No	Abnormal heart condition	Yes	No
Kidney disease	Yes	No	Stomach ulcers	Yes	No
Jaundice	Yes	No	Hepatitis	Yes	No
Epilepsy	Yes	No	Liver Disease	Yes	No
Diabetes	Yes	No	Tuberculosis	Yes	No
High Blood Pressure	Yes	No	Venereal Disease	Yes	No
Infectious mononucleosis	Yes	No	Heart Attack	Yes	No
Anemia or blood disorder	Yes	No	Heart Murmur	Yes	No
Tumor or malignancy	Yes	No	Stroke	Yes	No
Any other diseases	Yes	No			

18. Do you have any allergies or have you ever experienced an unusual reaction to any of the following drugs?
Antibiotics (penicillin, etc.) Yes No Codeine Yes No
Other medications? Yes No
If any, indicate which _____

19. Has there been any change in your general health in recent years? Yes No
20. Do you ever have asthma, hay fever, hives, skin rash, or allergies? Yes No
21. Have you ever had prolonged bleeding after a cut? Yes No
22. Do you breathe through your mouth very often? Yes No
23. Do you ever have chest pain, shortness of breath, or swelling of the ankles? Yes No
24. Have you recently lost weight unintentionally (with good appetite)? Yes No
25. Do you urinate frequently or drink large amounts of liquids? Yes No
26. Do you ever have fits or convulsions or a tendency to faint? Yes No
27. Are you excessively nervous? Yes No
28. (Females only) Are you pregnant? Yes No

29. Do you have any other medical or dental conditions or symptoms? Yes No
If so, explain _____

PHYSICIAN'S NAME _____ PHONE _____

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE _____ SIGNATURE _____

COMMENTS _____
