REGISTRATION / DENTAL /MEDICAL HISTORY INFORMATION

PATIENT NAME _____ SEX: M F BIRTH DATE _____
ADDRESS:
Street: _____ City _____ State _____ Zip _____
HOME PHONE # _____ WORK PHONE # _____ Cell / Other Phone # _____
SOC SEC # _____ E-MAIL ADDRESS _____
EMPLOYER/OCCUPATION _____
REFFERRED BY: _____ HOBBIES / INTERESTS: _____

RESPONSIBLE PARTY INFORMATION

NAME _____ Marital Status: Single / Married / Widowed / Divorced
ADDRESS -
Street _____ City _____ State _____ Zip _____
How long at this address: _____ Home Phone #_____Work Phone # _____Relationship to Patient _____
PREVIOUS ADDRESS (if less than 3 years) – Street _____City _____ State ____ Zip _____
Social Security # _____ Birth date _____Driver's License # _____ State _____
EMPLOYER _____ Occupation _____ # yrs. emp1oyed there _____

RESPONSIBLE PARTY'S SPOUSE
Name _____
Employer _____# yrs. emp1oyed there _____
Occupation _____ Soc Sec # _____
Work Phone # _____ Birth date_____

EMERGENCY INFORMATION:
Relative NOT living with you, NAME _____
Address _____
CITY, STATE & ZIP _____
PHONE # _____

DENTAL INSURANCE INFORMATION (Primary Carrier)
Insured's Name _____
Insured is: Self / Husband / Wife / Father / Mother /Other _____
Insurance Company _____
Insured's Employer _____
Insured's Social Sec # _____Birthdate_____

If you have double dental insurance coverage, complete this for the second coverage
Insured's Name _____
Insured is: Self / Husband / Wife / Father / Mother /Other _____
Insurance Company _____
Insured's Employer _____
Insured's Soc Sec # _____ Birthdate_____

DENTAL HISTORY

YES / NO Please Circle Y or N Below

Y N Do you think you have decay, gum disease, or jaw problems?
Y N Are you interested in improving your smile?
Y N Would you like to have whiter teeth?
Y N Have you ever considered bleaching, bonding, or braces?
Y N Are there any chips or stains on your teeth that concern you?
Y N Does food catch between your teeth? Any loose teeth?
Y N Do your gums ever bleed?
Y N Do you have clicking, popping or discomfort in your jaw joint?
Y N Do you grind or clench your teeth?

Y N Do you floss? How often? _____
What prompted you to seek dental care at this time? _____
When was your last visit to a dentist? _____
When last did you have your teeth examined? _____ Cleaned _____ X-rayed _____
Is your present dental health (please circle) Excellent Good Fair Poor
Previous dentist:_____ City _____ State _____
Reason for changing _____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease /Condition	Stroke	Epilepsy or Seizures	Tuberculosis (TB)	FOR WOMEN ONLY
Heart Surgery	Kidney Trouble / Stones	Psychiatric Treatment	Asthma	(please circle)
High/Low Blood Pressure	Ulcers	Glaucoma	Diabetes	
Taking BLOOD THINNERS	AIDS / ARC / HIV Pos.	Chemotherapy (cancer, leukemia)	Thyroid Disease	Taking Birth Control Pills
Heart Murmur	Hepatitis A (infectious)	Radiation Treatment	Arthritis	Possibly may be pregnant
Rheumatic Heart Disease	Hepatitis B C D (serum)	Autoimmune Disorder	Pain in Jaw Joints	Pregnant (#of months ___)
Heart Pacemaker	Liver Disease	Immunodeficiency	Alcoholism	Nursing
Artificial Joints (hip, knee)	Blood Transfusion	Venereal Disease	Unexplained Weight	In Menopause
Artificial Grafts / Implants	Drug Addiction	Bruise Easily	Gain/Loss	Perimenopause
Anemia	Hemophilia(bleeding problems)	Emphysema / COPD	Sinus Trouble/Hayfever	

ARE YOU ALLERGIC TO OR MADE SICK BY ANY OF THE FOLLOWING MEDICATIONS: (please circle)

Penicillin Codeine Latex rubber Aspirin Local Anesthetic Erythromycin Tetracycline Nitrous Oxide Iodine Sulfa Drugs Benzocaine Nickel

Are you aware of being allergic to or have adverse reactions to any other medications, foods, metals, substances, or earrings? YES NO Explain: _____
_____

ALSO, PLEASE COMPLETE AND SIGN BACK SIDE!

HEALTH HISTORY – Continued

General health (circle one) Excellent Good Fair Poor

Y N Do you smoke or chew? If so, how much? ______ packs/day/ # years ____

Y N Do you have any condition that requires antibiotic premedication before dental treatment? If yes, explain below.

Y N Have you been under the care of a medical doctor, had any serious illness, operation or been hospitalized in the past 3 years? Please explain:______

____

____

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____

____

Current drugs or medications and the conditions for which you are taking them: ____

____

____

____

____

Is there any other medical or dental information that you feel we should know about? YES NO

Explain:____

____

____

Physician's Name ___________________________ Phone: ________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I certify that I have read and understand both sides of this form. I acknowledge that my questions, if any, about the inquiries set forth above and on the other side of this form have been answered to my satisfaction. I will not hold my dentist, or any other member of his team responsible for any errors or omissions that I may have made in the completion of this form. 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 in connection with (Print Name of Patient) ____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I authorize the use of my radiographs, video/videotapes, and/or photographs for use in educational seminars or presentations or publications. I will allow the Doctor permission to discuss my conditions with my physician and to request medical information from him/her. Also, if I have any questions about any procedure I may ask the Doctor or any staff member at any time. I understand and agree that, (regardless of my insurance status) 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. This office does not carry open accounts. If due to unforeseen circumstances, your account should have an outstanding balance, there will be a $5.00 account service fee for each statement, letter, or phone call sent or made by our office to address past due balances. I further understand that a 1.5% finance charge (18% annually) will be added to any account balance over 30 days. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I have read all information on both sides of this sheet and have completed it to the best of my ability. I certify this information as true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. I also acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient ____ Date ______________ Witness ____________________________________

Parent or Responsible Party ____Relationship to Patient ___________________________

Medical History Update:

I have reviewed my MEDICAL HISTORY (BOTH SIDES OF THIS PAPER) My general health status and medication has changed as follows (if no change,write "NO CHANGE")

Date:	Changes:	Pt Signature:	Reviewed By: