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Patient Registration and Health History

Patient (First, M.I. Last) Home Phone

Address City State Zip

Sex: M F Birthdate Social Security # E-Mail

Dental History

What is the reason for your visit today?
Date of Last Dental Visit Last Dental Cleaning Last Full Mouth X-Rays
How often do you have dental examinations?
How often do you brush your teeth? How often do you floss?
What other dental aids do you use? (toothpick, mounthrinse, etc.)
Do you have any dental problems now? Yes No
If yes, please describe

Are any of your teeth sensitive to:

Hot or Cold? Yes No
Sweets? Yes No
Biting or chewing Yes No
Do your gums bleed or hurt? Yes No
Do you have any loose teeth? Yes No
Do you smoke/chew tobacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No
Oral Surgery? Yes No
Gum treatment? Yes No
Bite adjustments? Yes No
Bite plate or splint? Yes No
Serious mouth injury? Yes No

Do you;

Notice mouth odors or bat tastes? Yes No
Frequently get mouth sores? Yes No
Mouth breathe? Yes No

Get food caught around teeth? Yes No
Clench or grind your teeth? Yes No
Have tired jaws? Yes No

Have you experienced:

Clicking or popping of the jaw? Yes No
Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing? Yes No
Difficulty in chewing? Yes No

Do you feel nervous about having dental treatment? Yes No

Have you ever had an upsetting dental experience? Yes No

Overall, how would you evaluate your past dental treatment and experiences?

Excellent Good Fair Poor

Overall, how pleased are you with the appearance of your teeth and smile?

Extremely Pleased Moderately Pleased Satisfied Dissatisfied

Medical History

1. Have you been under the care of a physician during the past two years? Yes No

If yes, for what?

Physician's name Phone

Address City State Zip

2. Are you taking any medication, including non-prescription, now?

If yes, please list

(please complete other side)

3. List any allergies to drugs or substances _____

4. Indicate which of the following you have had, or have at present.

Heart(Surgery, Disease, Attack)	Yes	No	Asthma	Yes	No
Chest Pain	Yes	No	Latex Sensitivity	Yes	No
Congenital Heart Disease	Yes	No	Sinus Problems	Yes	No
Heart Murmur	Yes	No	Radiation Therapy	Yes	No
High Blood Pressure	Yes	No	Chemotherapy	Yes	No
Mitral Valve Prolapse	Yes	No	Cancer	Yes	No
Artificial Heart Valve	Yes	No	Thyroid Problems	Yes	No
Rheumatic Fever	Yes	No	Venereal Disease	Yes	No
Arthritis/Rheumatism	Yes	No	A.I.D.S. or HIV Infection	Yes	No
Cortisone/Steroid Medicine	Yes	No	Prolonged Bleeding	Yes	No
Stroke	Yes	No	Neurological disorders	Yes	No
Artificial Joints	Yes	No	Epilepsy or Seizures	Yes	No
Hepatitis, Jaundice, Liver Disease	Yes	No	Fainting or Dizzy Spells	Yes	No
Kidney Disease	Yes	No	Nervous/Anxious	Yes	No
Ulcers	Yes	No	Psychiatric Care	Yes	No
Diabetes	Yes	No	Chemical Dependency	Yes	No

5. Do you have any disease, condition, or problem not listed?

If yes, please list _____

6. Women:	Are you: Pregnant?	Yes	No	Nursing?	Yes	No
	Taking birth control pills				Yes	No

In case of any emergency, contact _____ Phone _____

Referred by _____

Dental Insurance

Employed by _____ Occupation _____

Business address _____ Business phone _____

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Spouse Name _____

Spouse Employed By _____ Occupation _____

Business Address _____ Business phone _____

Person Responsible for Account (or Guardian) _____ Relationship _____

Dental Insurance Company _____

Insured's Name _____ Insured's SS# _____ Insured's Date of Birth _____

Please sign below for the assignment of insurance benefits.

Signature _____ Date _____

Financial Arrangements

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. We accept cash, checks, and credit cards. We will be happy to help you process your insurance claim form. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1 1/2% per month

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. **Our treatment recommendations are based upon achieving optimum dental health and not based upon what your insurance company allows.**

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Singnature _____ Date _____