PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

TODAYS DATE_____DATE OF BIRTH_____

NAME_____SPOUSE_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE _____ WORK _____ CELL_____

E-MAIL _____ SOCIAL SECURITY#_____

PLACE OF EMPLOYMENT_____

IS ANY MEMBER OF YOUR FAMILY A PATIENT AT THIS OFFICE/WHO_____

PERSON TO CONTACT IN CASE OF EMERGENCY/PHONE_____

PHYSICIANS NAME_____ PHONE_____

REFERRED BY_____

DENTAL INSURANCE INFORMATION

NAME OF INSURANCE COMPANY_____

EMPLOYER_____

NAME OF INSURED_____ INSURED SS#_____

INSURED DOB _____GROUP # _____

PHONE #_____

HISTORY OF PRESENT COMPLAINT

SYMPTOMS DEVELOPING OVER LONG PERIOD OR RECENT_____
UPPER RIGHT_____UPPER LEFT_____LOWER RIGHT_____LOWER LEFT_____

ORAL HYGIENE AND HABITS

I BRUSH: AFTER EACH MEAL_____ ONCE OR TWICE PER DAY_____ NEVER_____
I USE: WATERPICK____ FLOSS____ RUBBER TIP____ INTERPLAK_____MOUTHWASH
ELECTRIC TOOTH BRUSH _____CLENCH OR GRIT TEETH_____

SMOKING: CIGARETTES—CIGARS—PIPE--CHEWING TOBACCO AMOUNT_____

HEALTH HISTORY

l. Are you having any pain or discomfort at this time?…… YES NO
2. Have you been a patient in the hospital during the past 2 years?……YES NO
3. Have you been under the care of a medical doctor during the past 2 years?……..YES NO
4. Are you taking any prescribed medications, vitamins, herbs or OTC ?……. YES NO
If yes, please list:_____
_____
5. Are you taking persantine or any other blood thinner at this time?…… YES NO
6. Do you take aspirin daily?_____if yes, how many?_____
7. Do you need to be pre-medicated with antibiotics for any dental treatment?…… YES NO
8. Do you get out of breath easily?…… YES NO
9. Do your ankles swell during the day?……YES NO
10. Do you suffer from frequent headaches?…… YES NO
11. Do you suffer from ear or eye trouble?…… YES NO
12. Have you ever been told that you had a tumor or cancer?…… YES NO
13. Are you on a special diet?…….YES NO
14. Do you take nitroglycerin?_____if so, how often?_____
15. Have you ever had any gum treatments?_____if so, when_____
16. FOR WOMEN ONLY: Are you pregnant?_____if yes, what month_____
Are you taking birth control pills?…… YES NO
17. Are you allergic or have you reacted adversely to any of the following medications?

Aspirin	**Nitrous Oxide**	**Valium**	**Local Anesthetic**
Darvon	**Erythomycin**	**Scopolamine**	**Novocain or Xylocaine**
Codeine	**Tetracycline**	**Penicillin**	**Sleeping Pills**
Demerol	**Percodan**	**Other Antibiotics**	**Nembutal/Seconal**

18. Are you aware of being allergic to any other medications or substance?……YES NO
if yes, please list:_____
19. Circle any of the following which you have had or have at present:

Heart failure	**Kidney or bladder trouble**	**Hemophilia**
Heart disease or attack	**Ulcers**	**X-ray or cobalt Tx.**
Angina Pectoris	**Emphysema**	**Chemotherapy**
Heart Murmur	**Tuberculosis**	**Drug Addiction**
Mitral Valve Prolapse	**Thyroid**	**Epilepsy or seizures**
Rheumatic fever	**Arthritis**	**Psychiatric Tx.**
Congenital heart lesions	**Rheumatism**	**Venereal Disease**
Artificial heart valve	**Asthma**	**Excessive bleeding**
High/low blood pressure	**Sinus trouble**	**Blood transfusions**
Scarlet fever	**Cold sores**	**Neuritis, neuralgia or neurosis**
Fever blisters	**Liver disease**	
Stroke	**Hives or general allergies**	**Artificial joints**
Glaucoma	**Hepatitis A**	**Yellow jaundice**
Hypoglycemia	**Hepatitis B**	**Diabetes (adolescent or maturity)**
Anemia	**Pain in jaw joints**	
AIDS		

20. Do you have any disease, condition or problem not listed ? If yes, please list_____

ALL INFORMATION IS TRUE ***Signature and Date*****_____**