

# 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**

- 1. 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:\_\_\_\_\_

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- 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
Fever blisters	Liver disease	neurosis
Stroke	Hives or general allergies	Artificial joints
Glaucoma	Hepatitis A	Yellow jaundice
Hypoglycemia	Hepatitis B	Diabetes (adolescent
Anemia	Pain in jaw joints	or maturity)
AIDS		

- 20. Do you have any disease, condition or problem not listed ? If yes, please list\_\_\_\_\_

ALL INFORMATION IS TRUE    *Signature and Date* \_\_\_\_\_