

Patient Number _____

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ Sex: M F Birthdate _____ AGE _____
 Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____
 Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ Sex: M F Birthdate _____ AGE _____
 RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____
 MAILING ADDRESS _____ Apt. # _____ City _____ State _____ Zip _____
 HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ WORK PHONE _____ CELL PHONE _____
 PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____
 SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____
 EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
 EMPLOYER _____ NO. OF YEARS EMPLOYED _____
 OCCUPATION _____ SOC. SEC. # _____
 WORK PHONE _____ BIRTHDATE _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____
 ADDRESS _____
 CITY, STATE _____ PHONE _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____
 Insurance Co. _____
 Insurance Co. Address _____
 Insured's Soc. Sec. # _____ Group # _____ Local # _____

DENTAL INSURANCE INFORMATION (Secondary Carrier)

Insured's Name _____
 Insurance Co. _____
 Insurance Co. Address _____
 Insured's Soc. Sec. # _____ Group # _____ Local # _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

*DENTAL HISTORY	YES	NO	*MEDICAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?			Do you have any CURRENT HEALTH PROBLEMS?	<input type="checkbox"/>	<input type="checkbox"/>
Last COMPLETE Dental Exam, Date:			Are you under a PHYSICIAN'S CARE now?	<input type="checkbox"/>	<input type="checkbox"/>
Last FULL MOUTH X-RAYS, DATE:			for what?		
Are you having PROBLEMS now?	<input type="checkbox"/>	<input type="checkbox"/>	What MEDICATIONS are you currently taking?		
WHAT?			Are you PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
Is your present dental health POOR?	<input type="checkbox"/>	<input type="checkbox"/>	Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear DENTURES? (Partials or Full)	<input type="checkbox"/>	<input type="checkbox"/>	CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:		
Are you UNHAPPY with your dentures?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease or Attack	AIDS/ARC/HIV Pos.	Bruise Easily
Would you like to know more about PERMANENT REPLACEMENTS?	<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	Hepatitis A	Emphysema
Are you APPREHENSIVE about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Have you had any PERIODONTAL (GUM) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	Hepatitis C	Asthma
Do your gums BLEED, or feel TENDER or IRRITATED?	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	Liver Disease	Hay Fever
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Lesions	Blood Transfusion	Sinus Trouble
Are you UNHAPPY with the APPEARANCE of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	Drug Addiction	Allergies or Hives
Are you aware of GRINDING or CLENCHING your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	Hemophilia (Bleeding Problems)	Diabetes
Do you have HEADACHES, EARACHES, or NECK PAINS?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker	Fever Blisters	Thyroid Disease
Have you worn BRACES on your teeth (ORTHODONTICS)?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	Epilepsy or Seizures	Radiation Treatment
Do you have DISCOLORED teeth that bother you?	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints (Hip, Knee)	Nervousness	Arthritis
Would you like your smile to LOOK BETTER or DIFFERENT?	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	Psychiatric Treatment	Cortisone Medicine
Do you REGULARLY use DENTAL FLOSS?	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	Glaucoma	Pain in Jaw Joints
			Kidney Trouble	Chemotherapy (Cancer, Leukemia)	Alcoholism
			Ulcers	Venereal Disease (Syphilis, Gonorrhea, etc)	Cosmetic Surgery
ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?					
Aspirin		Local Anesthetic		Erythromycin	
Nitrous Oxide		Codeine		Penicillin	
				Latex (balloons, gloves, etc.)	
Are you aware of being allergic to any other medications or substance? _____					
If yes, please list: _____					
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.					
FEAR of pain	#	LACK of concern	#		
COST of treatment	#	MISSING work time	#		
Name of Previous Dentist: _____			FAMILY PHYSICIAN _____ PHONE NO. _____		
City: _____ State: _____					
How do you feel about your teeth? _____					
Is there any other Medical or Dental information that you feel I should know about? _____					

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____