Patient Registration and Health History
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About You

Today's Date_____

E-mail Address: _____

Name: _____

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/ ___/ ___ Age: _____ SS#: _____

Home Address: _____

_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #(____)_____ Cell #(____)_____

Work #(____)_____ ext _____

Employer: ____ _____

How long there? _____ Occupation: _____

Where and when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Date of Last Dental Visit:_____

Spouse Information

His/Her Name: _____

Employer: _____

Work # (____)_____ Ext: ____ SS# _____

Birthdate: ___/ ___/ ____

Person Responsible for Account: _____

Work # (____)_____ Home # (____)_____

Billing Address: _____

Relationship: _____ SS#: _____

Employer: _____

Insurance

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured Name: _____ Relationship: _____

Insured Birthdate: ___/ ___/ ___ Insured ID #: _____

Insured Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured Name: _____ Relationship: _____

Insured Birthdate: ___/ ___/ ___ Insured ID #: _____

Insured Employer: _____

Employer's Address: _____

Emergency Contact

Name: _____ Relationship: _____

Work # (____)_____ Home # (____)_____

Cell# (___) _____

Address: _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Date of last Visit:_____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please Explain: _____

Medical History Continued

Your current health is: ☐ Good ☐ Fair ☐ Poor
Do you smoke or use tobacco? Y N
Do you drink alcohol? Y N If yes, how many per week? _____
Have you had any metal rods, pins, or implants? Y N Year_____
Have you been hospitalized for any reason? Y N
Is so, explain: _____
Are you taking any prescriptions, over-the-counter or herbal medications? Y N
Please list each one: _____
_____
_____
_____

Have you ever taken Fosamax or other medications for osteoporosis? Y N

For Women:
Are you using a prescribed method of birth control? Y N
Are you pregnant Y N Week # _____
Are you nursing? Y N

Have you ever had any of the following diseases or medical problems? Circle Y or N.

Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Alcohol/Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+/AIDS
Y	N	Arthritis	Y	N	Hospitalized for Any Reason
Y	N	Artificial bones/joints/valve	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer/Chemotherapy	Y	N	Lupus
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Osteoporosis/ Paget's Disease
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Problems
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic/Scarlet Fever
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease/Traits
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had: ___
_____
_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other
Y	N	Dental Anesthetics	Y	N	Penicillin			

Please list any other drugs/materials you are allergic to: _____
_____
_____

Dental History

Why have you come to the dentist today? _____
_____

Do you require antibiotics before dental treatment? Y N
Are you currently in pain? Y N
Have you ever had a serious/difficult problem associated with any dental treatment? Y N
Have you ever had gum treatment? Y N
Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? Y N
Your current dental health is ___Good ___Fair ____Poor
Do you like your smile? Y N
Do your gums bleed? Y N
How many times a week do you floss? _____
How many times a day do you brush your teeth? _____
Type of bristles? ____Soft ____Medium _____Hard
Are your teeth sensitive to heat/cold/or anything else?
_____
Have you lost any teeth? Y N
If yes, why? _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____
Signature Date

Payment is due in full at time of treatment
unless prior arrangements have been approved.

This office accepts insurance, therefore I understand that I am responsible for payment of the service rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

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I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____
_____