PATIENT REGISTRATION
AND
MEDICAL/DENTAL HISTORY

Medical Alert

So that we may provide you with the best possible care, please complete both sides of this medical/dental history form.

(PLEASE PRINT) Date ____________________

Patient Name ____
Last First Middle Initial Name Called By

Address ____

City ____________ State ______ Zip ______ Tel. __________ Social Security # ____________

Sex: ☐ Male ☐ Female Age ______ Birthday __/__/____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed By ____________________ Occupation ____________________

Business Address ____

City ____________________ State ______ Zip ______ Tel. __________ Ext. ______

Spouses Name ____________________ Birthday __/__/____ Employed By ____________________

Business Address ____

City ____________ State ______ Zip ______ Tel. __________ Social Security # ____________

Who is responsible for this account? ____________________ Relationship to Patient ____________

Dental Insurance Primary Carrier		
Insured's Name	Social Security #	
Insurance Company		
Address		
Group Number	ID Number	Birthdate
Insured's Employer		

Dental Insurance Secondary Carrier		
Insured's Name	Social Security #	
Insurance Company		
Address		
Group Number	ID Number	Birthdate
Insured's Employer		

In case of emergency, who should be notified? ____________________ Tel. ____________

Whom may we thank for referring you? ______________________________

MEDICAL HISTORY

Physician's Name ____________________ Date of Last Physical ____________

Address ______________________________ Tel. ____________

Please check the box of any condition you may have had.

☐ Heart Disease or Attack	☐ Hepatitis, Jaundice or Liver Disease	☐ Artificial Heart Valves	☐ "A.I.D.S."/ HIV Positive or Other	☐ Special Diet
☐ Heart Murmur	☐ Epilepsy/Seizures	☐ Artificial Joints	☐ Tuberculosis	☐ Swollen Neck Glands
☐ Heart Pacemaker	☐ Stroke	☐ Recent Weight Loss	☐ Respiratory Problem	☐ Rheumatic Fever
☐ Angina Pectoris	☐ Headaches	☐ General Allergies	☐ Kidney Problem	☐ Sinus Problems
☐ Mitral Valve Prolapse	☐ Cancer, Leukemia	☐ Blood Disease	☐ Thyroid Disease	☐ Ulcer
☐ High Blood Pressure	☐ Chronic Diarrhea	☐ Back Problems	☐ Glaucoma	☐ Venereal Disease
☐ Low Blood Pressure	☐ Allergies to Anesthetics	☐ Nervous Problems	☐ Diabetes	☐ Chemical Dependency
☐ Circulatory Problems	☐ Contact Lenses	☐ Psychiatric Care	☐ Arthritis/Rheumatism	☐ Hemophilia
☐ Asthma	☐ Hypoglycemia	☐ Allergy to Latex	☐ Allergy to Colored Dyes	☐ Blood Transfusion

Patient Name

DENTAL HISTORY

What is the reason for your visit today? ____________________

____

Is there anything about having dental treatment that you would like us to know? Yes ☐ No ☐
If yes, please describe ____________________

____

____

Date of Last: **Dental Visit** ________ **Dental Cleaning** ________ **Full Mouth X-Rays** ________ **Bitewing X-rays** ________
What treatment was done at your last dental visit? ____________________

____

Previous Dentists Name ____________________ Telephone ____________________
Address ____________________
City ____________________ State ____________________ Zip Code ____________________
How often do you have dental examinations? ____________________ How often do you floss? ____________________
What other dental aids do you use? (Interplak, toothpick etc.) ____________________
Do you have any dental problems now? ☐ Yes ☐ No If yes, please describe ____________________

Circle "yes" or "no" to each item

Do You:

Clench or grind your teeth while awake or asleep?	**Yes**	**No**
Bite your lips or cheeks regularly?	**Yes**	**No**
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	**Yes**	**No**
Mouth breathe while awake or asleep?	**Yes**	**No**
Have tired jaws, especially in the morning?	**Yes**	**No**
S0moke/chew tobacco?	**Yes**	**No**
How much? ________		

Have you ever had:

Orthodontic treatment?	**Yes**	**No**
Oral Surgery?	**Yes**	**No**
Periodontal treatment?	**Yes**	**No**
Your teeth ground or the bite adjusted?	**Yes**	**No**
A bite plate or mouth guard?	**Yes**	**No**
A serious injury to the head?	**Yes**	**No**

If yes, please describe, including cause.

____

Are any of your teeth sensitive to:

Hot or cold	**Yes**	**No**
Sweet	**Yes**	**No**
Biting or chewing	**Yes**	**No**
Have you noticed any mouth odors or bad tastes?	**Yes**	**No**
Do you frequently get cold sores, blisters or any other oral lesions?	**Yes**	**No**
Do your gums bleed or hurt?	**Yes**	**No**
Have your parents experienced gum disease or tooth loss?	**Yes**	**No**
Have you noticed any loose teeth or a change in your bite?	**Yes**	**No**
Do you have difficulty in chewing on either side of the mouth	**Yes**	**No**
Does food tend to be caught in between your teeth?	**Yes**	**No**

If yes, where? ____________________

____

Have you experienced:

Clicking or popping of the jaw?	**Yes**	**No**
Pain? (joint, ear, side, or face)	**Yes**	**No**
Difficulty in opening or closing the mouth?	**Yes**	**No**
Headaches, neckaches or shoulder aches?	**Yes**	**No**
Sore muscles (neck, shoulders)?	**Yes**	**No**
Are you satisfied with your teeth's appearance?	**Yes**	**No**
Would you like to keep all of your teeth all of your life?	**Yes**	**No**
Do you feel nervous about having dental treatment?	**Yes**	**No**

If yes, what is your biggest concern?

____

Have you ever had an upsetting dental experience?	**Yes**	**No**

If yes, please describe ____________________

____

Do you have any drug allergies or have you ever had an adverse reaction to any medication or substance? Yes ☐ No ☐
If yes, list ____________________
Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No
Are you taking any medications at this time? ☐ Yes ☐ No If yes, what ____________________

____

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what condition ____________________
Women - Are you: Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No
Is there anything else we should know about your medical history? ____________________

____

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing, and processing of insurance for benefits for which I am entitled.
I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____________________ ____________________
Signature of patient or parent if minor Date