REGISTRATION HISTORY

Date_____Age_____Birthday_____
Patient's Name_____ Single____
Name of Spouse_____ Married____
If A Child, Parent's Name_____ Widowed____
Mailing Address_____ Divorced____
Street Address_____Separated____
City_____State_____Zip_____
Home Phone_____
Patient Employed By_____Phone_____
Business Address_____
Present Position_____How Long Held_____
Spouse Employed By_____Phone_____
Business Address_____
Present Position_____How Long Held_____
In case of emergency, whom should be notified_____
WHO WILL PAY THIS ACCOUNT_____
Social Security #_____Spouse's Social Security #_____
Do you have insurance that may cover any part of our professional services?
Yes_____ No_____
If so, Name of the Company_____
Subscriber SSN_____Place of Employment_____
Subscriber's Birthdate_____
Whom May We Thank Referring You?_____

Dental History

1. What are your reasons for seeking dental care?_____
_____

2. Are you dissatisfied with the appearance of your teeth?	Yes	No
3. Have you ever experienced an unusual reaction to a dental anesthetic?	Yes	No
4. Do you have difficulty chewing food?	Yes	No
5. Do you have sensitive or aching teeth?	Yes	No
6. Do you have sore or bleeding gums?	Yes	No
7. Do you ever have sores in the mouth or on the lips?	Yes	No
If yes, are they present longer that 2-3 weeks?	Yes	No
8. Have you ever had any injury to your face or jaws?	Yes	No
9. Do you have sinus trouble?	Yes	No
10. Do you clench or grind your teeth?	Yes	No
11. Have you had braces, root canals,or gum surgery?	Yes	No

MEDICAL HISTORY

12. Are you presently in good health? Yes No

13. Have you been examined by a physician within the last 5 years? Yes No
    If so, for what reason? _____
_____

14. Are you being treated by a physician for any condition at this time? Yes No
    If so, explain_____
_____

15. Have you ever been seriously ill, been hospitalized, or had a surgical operation? Yes No
    If so, explain? _____

16. Are you taking any prescription or non-prescription medications (Any form or pills, tablets, or syrups) now or have you within the past six (6) weeks? Yes No
    If so, what?_____
_____

17. Do you have or have you ever had?

Rheumatic Fever	Yes	No	Abnormal heart condition	Yes	No
Kidney disease	Yes	No	Stomach ulcers	Yes	No
Jaundice	Yes	No	Hepatitis	Yes	No
Epilepsy	Yes	No	Liver Disease	Yes	No
Diabetes	Yes	No	Tuberculosis	Yes	No
High Blood Pressure	Yes	No	Venereal Disease	Yes	No
Infectious mononucleosis	Yes	No	Heart Attack	Yes	No
Anemia or blood disorder	Yes	No	Heart Murmur	Yes	No
Tumor or malignancy	Yes	No	Stroke	Yes	No
Any other diseases	Yes	No			

18. Do you have any allergies or have you ever experienced an unusual reaction to any of the following drugs?

Antibiotics (penicillin, etc.)	Yes	No	Codeine	Yes	No
Other medications?	Yes	No			

    If any, indicate which_____

19. Has there been any change in your general health in recent years? Yes No
20. Do you ever have asthma, hay fever, hives, skin rash, or allergies? Yes No
21. Have you ever had prolonged bleeding after a cut? Yes No
22. Do you breathe through your mouth very often? Yes No
23. Do you ever have chest pain, shortness of breath, or swelling of the ankles? Yes No
24. Have you recently lost weight unintentionally (with good appetite)? Yes No
25. Do you urinate frequently or drink large amounts of liquids? Yes No
26. Do you ever have fits or convulsions or a tendency to faint? Yes No
27. Are you excessively nervous? Yes No
28. (Females only) Are you pregnant? Yes No

29. Do you have any other medical or dental conditions or symptoms? Yes No
    If so, explain_____

PHYSICIAN'S NAME_____PHONE_____

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE_____ SIGNATURE_____

COMMENTS_____
_____
_____
_____
_____
_____
_____