Patient Number _____ A B C

# 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 _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

## RESPONSIBLE PARTY'S SPOUSE

NAME _____ (LAST / FIRST / MIDDLE)

EMPLOYER _____ OCCUPATION _____ ( ) NO. YEARS EMPLOYED

SOC. SEC. # _____ BIRTHDATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____ E-MAIL _____

## EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY, STATE _____

HOME PH. _____ CELL PH. _____

WORK PH. _____

## DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

**If you have double dental insurance coverage, complete this for the second coverage.**

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

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 |
|---|---|---|
| HOW LONG SINCE you have seen a dentist? | | |
| Last COMPLETE Dental Exam, Date: | | |
| Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic) | | |
| Are you having PROBLEMS now? | ☐ | ☐ |
| WHAT? | | |
| Is your present dental health POOR? | ☐ | ☐ |
| Do you wear DENTURES? (Partials or Full) | ☐ | ☐ |
| Are you UNHAPPY with your dentures? | ☐ | ☐ |
| Would you like to know more about PERMANENT REPLACEMENTS? | ☐ | ☐ |
| Are you APPREHENSIVE about dental treatment? | ☐ | ☐ |
| Have you had any PERIODONTAL (GUM) treatments? | ☐ | ☐ |
| Do your gums BLEED, or feel TENDER or IRRITATED? | ☐ | ☐ |
| Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle) | ☐ | ☐ |
| Are you UNHAPPY with the APPEARANCE of your teeth? | ☐ | ☐ |
| Are you aware of GRINDING or CLENCHING your teeth? | ☐ | ☐ |
| Do you have HEADACHES, EARACHES, or NECK PAINS? | ☐ | ☐ |
| Have you worn BRACES on your teeth (ORTHODONTICS) | ☐ | ☐ |
| Do you have DISCOLORED teeth that bother you? | ☐ | ☐ |
| Would you like your smile to LOOK BETTER or DIFFERENT? | ☐ | ☐ |
| Do you REGULARLY use DENTAL FLOSS? | ☐ | ☐ |

Name of Previous Dentist:

City: State:

How do you feel about your teeth?

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 #

| *MEDICAL HISTORY* | YES | NO |
|---|---|---|
| Do you have any CURRENT HEALTH PROBLEMS? | ☐ | ☐ |
| Are you under a PHYSICIAN'S CARE now? | ☐ | ☐ |
| For what? | | |
| What MEDICATIONS are you currently taking? | | |
| | | |
| Have you ever taken Fen-Phen/Redux? | ☐ | ☐ |
| Are you PREGNANT? | ☐ | ☐ |
| Do you use cigars/cigarettes, pipe or chewing tobacco? (circle) | ☐ | ☐ |

**PLEASE ✔ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:**

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV Pos. | ☐ | ☐ | Fainting | ☐ | ☐ | Psychiatric care | ☐ | ☐ |
| Anaphylaxis | ☐ | ☐ | Food allergies | ☐ | ☐ | Rapid weight gain/loss | ☐ | ☐ |
| Anemia | ☐ | ☐ | Glaucoma | ☐ | ☐ | Radiation treatment | ☐ | ☐ |
| Arthritis (Rheumatism) | ☐ | ☐ | Headaches | ☐ | ☐ | Respiratory disease | ☐ | ☐ |
| Artificial heart valves | ☐ | ☐ | Heart murmur | ☐ | ☐ | Rheumatic/scarlet fever | ☐ | ☐ |
| Artificial joints | ☐ | ☐ | Heart problems (please describe) | ☐ | ☐ | Shingles | ☐ | ☐ |
| Asthma | ☐ | ☐ | _____ | | | Shortness of breath | ☐ | ☐ |
| Atopic (Allergy Prone) | ☐ | ☐ | Hemophilia (Abnormal bleeding) | ☐ | ☐ | Skin rash | ☐ | ☐ |
| Back problems | ☐ | ☐ | Herpes | ☐ | ☐ | Spina Bifida | ☐ | ☐ |
| Blood disease | ☐ | ☐ | Hepatitis | ☐ | ☐ | Stroke | ☐ | ☐ |
| Cancer | ☐ | ☐ | High blood pressure | ☐ | ☐ | Surgical implant | ☐ | ☐ |
| Chemical dependency | ☐ | ☐ | Jaw pain | ☐ | ☐ | Swelling of feet or ankles | ☐ | ☐ |
| Chemotheropy | ☐ | ☐ | Kidney disease or malfunction | ☐ | ☐ | Thyroid disease or malfunction | ☐ | ☐ |
| Circulatory problems | ☐ | ☐ | Liver disease | ☐ | ☐ | Tobacco habit | ☐ | ☐ |
| Cortisone treatments | ☐ | ☐ | Material allergies | ☐ | ☐ | Tonsillitis | ☐ | ☐ |
| Cough (persistent) | ☐ | ☐ | (latex, wool, metal, chemicals) | | | Tuberculosis | ☐ | ☐ |
| Cough up blood | ☐ | ☐ | Mitral valve prolapse | ☐ | ☐ | Ulcer/Colitis | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Nervous problems | ☐ | ☐ | Venereal disease | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | Pacemaker/heart surgery | ☐ | ☐ | | | |

**ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?**

Aspirin, Nitrous Oxide, Local Anesthetic, Codeine, Erythromycin, Penicillin, Latex (balloons, gloves, etc.)

Are you aware of being allergic to any other medications or substances?

If yes, please list:

*Is there any other Medical or Dental information that you feel I should know about?*

FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____

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