

Patient's Number \_\_\_\_\_ A B C

# HEALTH HISTORY & REGISTRATION

Today's Date \_\_\_\_\_

## PATIENT INFORMATION

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Sex:  M  F Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_ Reason for visit \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Last Name \_\_\_\_\_ 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 \_\_\_\_\_ Work Phone \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell Phone \_\_\_\_\_

Previous Address (if less than 3 yrs): Street \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_ Driver's License # \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

## RESPONSIBLE PARTY'S SPOUSE

Name \_\_\_\_\_

Employer \_\_\_\_\_ No. 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 Employer \_\_\_\_\_

Insured's SS# \_\_\_\_\_

Group # \_\_\_\_\_ Local # \_\_\_\_\_

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

Insured's Name \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's SS# \_\_\_\_\_

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

HOW LONG SINCE you have seen a dentist? \_\_\_\_\_

Last COMPLETE dental exam, Date: \_\_\_\_\_

Last FULL MOUTH X-RAYS, Date: \_\_\_\_\_  16 Small Films  Panoramic?

Are you having problems now?  Yes  No What? \_\_\_\_\_

Is your present dental health POOR?  Yes  No

Do you wear DENTURES? (Partials or Full)  Yes  No

Are you UNHAPPY with your dentures?  Yes  No

Would you like to know more about PERMANENT REPLACEMENTS?  Yes  No

Are you APPREHENSIVE about dental treatment?  Yes  No

Have you had any PERIODONTAL (GUM) treatments?  Yes  No

Do your gums BLEED or feel TENDER or IRRITATED?  Yes  No

Are you UNHAPPY with the APPEARANCE of your teeth?  Yes  No

Are you aware of GRINDING or CLENCHING your teeth?  Yes  No

Do you have HEADACHES, EARACHES, or NECK PAINS?  Yes  No

Have you work BRACES on your teeth (ORTHODONTICS)?  Yes  No

Do you have DISCOLORED teeth that bother you?  Yes  No

Would you like your smile to LOOK BETTER or DIFFERENT?  Yes  No

Do you REGULARLY use DENTAL FLOSS?  Yes  No

Are your teeth SENSITIVE to  hot  cold  sweets  pressure?

Name of Previous Dentist \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

How do you feel about your teeth? \_\_\_\_\_

Please rank the following in order in which they would keep you from having dental treatment.

Fear of pain \_\_\_\_\_

Cost of treatment \_\_\_\_\_

Lack of concern \_\_\_\_\_

Missing work time \_\_\_\_\_

## MEDICAL HISTORY

Do you have any CURRENT HEALTH PROBLEMS?  Yes  No

Are you under a PHYSICIAN'S CARE NOW?  Yes  No For what? \_\_\_\_\_

Are you PREGNANT?  Yes  No

Do you use  cigars/cigarettes  pipe  chewing tobacco?

What MEDICATIONS are you currently taking? \_\_\_\_\_

**Check any of the following which you have had, or presently have:**

- |  |  |   |   |   |
|--|--|---|---|---|
| <input type="radio"/> Heart disease or attach  | <input type="radio"/> Artificial Joints        | <input type="radio"/> Liver Disease         | <input type="radio"/> Chemotherapy      | <input type="radio"/> Allergies or Hives  |
| <input type="radio"/> Angina Pectoris          | (Hip, Knee)                                    | <input type="radio"/> Blood Transfusion     | (Cancer, Leukemia)                      | <input type="radio"/> Diabetes            |
| <input type="radio"/> High Blood Pressure      | <input type="radio"/> Anemia                   | <input type="radio"/> Drug Addiction        | <input type="radio"/> Venereal Disease  | <input type="radio"/> Thyroid Disease     |
| <input type="radio"/> Heart Murmur             | <input type="radio"/> Stroke                   | <input type="radio"/> Hemophilia            | (Syphilis, Gonorrhea, etc.)             | <input type="radio"/> Radiation Treatment |
| <input type="radio"/> Rheumatic Fever          | <input type="radio"/> Kidney Trouble           | (Bleeding Problems)                         | <input type="radio"/> Bruise Easily     | <input type="radio"/> Arthritis           |
| <input type="radio"/> Congenital Heart Lesions | <input type="radio"/> Ulcers                   | <input type="radio"/> Fever Blisters        | <input type="radio"/> Emphysema         | <input type="radio"/> Cortisone Medicine  |
| <input type="radio"/> Mitral Valve Prolapse    | <input type="radio"/> AIDS/ARC/HIV Pos.        | <input type="radio"/> Epilepsy of Seizures  | <input type="radio"/> Tuberculosis (TB) | <input type="radio"/> Pain in Jaw Joints  |
| <input type="radio"/> Artificial Heart Valve   | <input type="radio"/> Hepatitis A (Infectious) | <input type="radio"/> Nervousness           | <input type="radio"/> Asthma            | <input type="radio"/> Alcoholism          |
| <input type="radio"/> Heart Pacemaker          | <input type="radio"/> Hepatitis B (serum)      | <input type="radio"/> Psychiatric Treatment | <input type="radio"/> Hay Fever         | <input type="radio"/> Cosmetic Surgery    |
| <input type="radio"/> Heart Surgery            | <input type="radio"/> Hepatitis C              | <input type="radio"/> Glaucoma              | <input type="radio"/> Sinus Trouble     |   |

**Are you allergic to or have you reacted adversely to any of the following medications:**

- |                                     |  |                                    |  |
|-------------------------------------|--|------------------------------------|--|
| <input type="radio"/> Aspirin       | <input type="radio"/> Local Anesthetic | <input type="radio"/> Erythromycin | <input type="radio"/> Latex (balloons, gloves, etc.) |
| <input type="radio"/> Nitrous Oxide | <input type="radio"/> Codeine          | <input type="radio"/> Penicillin   |  |

Are you aware of being allergic to any other medications or substances?  Yes  No Please list \_\_\_\_\_

Is there any other medical or dental information that you feel I should know about? \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

PATIENT Signature (Parent of Child) \_\_\_\_\_ Date \_\_\_\_\_ DENTIST Signature \_\_\_\_\_