

### HEALTH HISTORY & REGISTRATION

Patients Name: \_\_\_\_\_ Sex: M F Birthdate: \_\_\_\_\_  
 Marital Status: Married Single Parent's Name if minor: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_ Referred By: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION (PRIMARY)**

Insured's Name: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Insurance Carrier: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**HEALTH HISTORY...Do any of the following pertain to your health?**

AIDS	Anemia	Angina Pectoris	Arthritis
Artificial Joints	Asthma	Blood Disease	Chemotherapy/Radiation (Cancer, Leukemia)
Cortisone Medicine	Diabetes	Dizziness/Fainting	Drug Addiction
Emphysema	Epilepsy/Seizures	Excessive Bleeding	Glaucoma
Growths	Head Injuries	Heart Disease	Heart Murmur
Hepatitis	High Blood Pressure	Jaundice	Kidney Disease
Liver Disease	Mental Disorders	Nervous Disorders	Pacemaker/Heart Valve
Pregnancy (Due Date _____)	Psychiatric Treatment	Respiratory Problems	Rheumatic Fever
Rheumatism	Sinus Problems	Stroke	Thyroid Disease
Tuberculosis	Tumors	Ulcers	Venereal Disease (Syphilis, Gonorrhea, etc)

- Do you have any allergies to medications or Latex? Yes No  
If yes, please list: \_\_\_\_\_
- Have you ever had any complications following dental treatment? Yes No  
If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician? Yes No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification? Yes No  
If yes, please explain: \_\_\_\_\_
- Please list any medications you are currently taking: \_\_\_\_\_

**Consent:**

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

Patient Signature (Parent of Child) \_\_\_\_\_ Date: \_\_\_\_\_  
 Dentist Signature \_\_\_\_\_ Date: \_\_\_\_\_