

Patient Number _____ A B C

HEALTH HISTORY & REGISTRATION

Patient's Name _____ Sex: M F Birthdate _____ Age _____ Today's Date _____

Home Address _____ City _____ State _____ Zip _____

Previous Address (if less than 3 years) _____ City _____ State _____ Zip _____

Please Circle One: Single, Married, Separated, Divorced, Widowed Occupation _____ Home Phone Number _____

Your Employer _____ How Long Employed? _____ Your Soc. Sec. # _____ Work Phone _____

Are you a full time student? Yes No If Patient is a minor we need: Mother's Birthdate _____ Father's Birthdate _____

Name of Spouse (Parent If Minor) _____ Person Responsible For Account _____

Spouse's (Parent's) Employer _____ Spouse's Soc. Sec. # _____ Work Phone _____

Referred to us by _____ EMERGENCY INFORMATION

Reason for this visit _____ Name, Address & Telephone of a Relative Not Living with you _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insured's DOB _____

Insurance Co. _____

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. _____

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	*MEDICAL HISTORY*	YES	NO
How LONG SINCE you have seen a Dentist?			Do you have any CURRENT HEALTH PROBLEMS?	<input type="checkbox"/>	<input type="checkbox"/>
Last COMPLETE Dental Exam, Date:			Are you under a PHYSICIAN'S CARE now?	<input type="checkbox"/>	<input type="checkbox"/>
Last FULL MOUTH X-RAYS, DATE: <i>(Machine that rotates around your head, or 16 small films.)</i>			For What?		
Are you having PROBLEMS now?	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently taking any medication?	<input type="checkbox"/>	<input type="checkbox"/>
WHAT?			If yes, what?		
Is your present dental health POOR?	<input type="checkbox"/>	<input type="checkbox"/>	Circle any of the following which you have had or have at present:		
Do you wear DENTURES? (Partials or Full)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure	A.I.D.S.	Bruise Easily
Are you UNHAPPY with your dentures?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease or Attack	Hepatitis A (infectious)	Emphysema
Would you like to know more about PERMANENT REPLACEMENTS?	<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	Hepatitis B (serum)	Tuberculosis (TB)
Have you had BAD dental experiences in the past?	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	Liver Disease	Asthma
Are you APPREHENSIVE about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	Yellow Jaundice	Hay Fever
Have you had any PERIODONTAL (GUM) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	Blood Transfusion	Sinus Trouble
Do your gums BLEED, or feel TENDER or IRRITATED?	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Lesions	Drug Addiction	Allergies or Hives
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	Hemophilia	Diabetes
Are you UNHAPPY with the APPEARANCE of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	Fever Blisters	Thyroid Disease
Are you aware of GRINDING or CLENCHING your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker	Epilepsy or Seizures	X-ray or Cobalt Treatment
Do you have HEADACHES, EARACHES, or NECK PAINS?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	Fainting or Dizzy Spells	Arthritis
Do you have LOOSE, TIPPED, or SHIFTING teeth? (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints (Hip, Knee)	Nervousness	Rheumatism
Have you worn BRACES on your teeth? (ORTHODONTICS)	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	Psychiatric Treatment	Cortisone Medicine
Do you have DISCOLORED teeth that bother you?	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	Sickle Cell Disease	Pain in Jaw Joints
Would you like your smile to LOOK BETTER or DIFFERENT?	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	Glaucoma	
Do you have problems with teeth/fillings BREAKING?	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	Chemotherapy (Cancer, Leukemia)	
Do you REGULARLY use DENTAL FLOSS?	<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Surgery	Venereal Disease (Syphilis, Gonorrhea, etc.)	
Would you like us to help you learn proper methods of Home Care, so you can stop dental problems in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic or have you reacted adversely to any of the following medications?		
Name of Previous Dentist:			Aspirin	Percodan	Erythromycin
City:		State:	Darvon	Local Anesthetic	Valium
How do you feel about your teeth?			Nitrous Oxide	Codeine	Penicillin
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.			Are you aware of being allergic to any other medications or substances?		
FEAR of pain #		LACK of concern #	If yes, please list: _____		
COST of treatment #		MISSING work time #	FAMILY PHYSICIAN: _____ PHONE NO. _____		

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 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 _____