



HEALTH HISTORY AND REGISTRATION

PATIENT

Patient Name: Last _____ First _____ Middle Initial _____ Nickname _____
 Address: Street _____ City _____ State _____ Zip _____
 Home Phone: _____ Work Phone: _____ Cell/Pager: _____
 Employer: _____ Occupation: _____ E-Mail _____
 Sex: M F Birth Date: _____ Marital Status _____ Whom may we thank for referring you to our office? _____
 Reason for today's visit _____ Last Dental Visit _____

SPOUSE/PARENT/GUARDIAN INFORMATION

Name: Last _____ First _____ Middle Initial _____ Marital Status: _____
 Address: Street _____ City _____ State _____ Zip _____
 Home Phone: _____ Work Phone: _____ Cell/Pager: _____
 Employer: _____ Occupation: _____ E-Mail: _____
 Relationship to Patient: _____

DENTAL INSURANCE (PRIMARY CARRIER)

Insured's Name _____
 Insurance Co. _____
 Insurance Co. Address _____
 Insured's Employer _____
 Insured's SS/ID # _____
 Group _____ Ins Co. Phone _____

SECONDARY (IF APPLIES)

Insured's Name _____
 Insurance Co. _____
 Insurance Co. Address _____
 Insured's Employer _____
 Insured's SS/ID # _____
 Group _____ Ins Co. Phone _____

We need to know about your medical and dental history. This information is confidential. Thank you for taking the time to fill out this questionnaire.

MEDICAL HISTORY

Name of Physician: _____ Office Phone: _____ Date of Last Exam: _____

- | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------|-----|----|---------------------------------------------------------------------------------------|-----|----|
| | Yes | No | | Yes | No |
| 1. Are you under medical treatment now?..... | | | 10. Are you allergic to any of the following? | | |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?....
If yes, please explain _____ | | | Local Anesthetics (e.g. Novocain)..... | | |
| 3. Are you taking any medication(s) including non-prescription medicine?.....
If yes, what medication(s) are you taking? _____ | | | Penicillin or any other Antibiotics..... | | |
| 4. Have you ever taken Fen-Phen/Redux?..... | | | Sulfa Drugs..... | | |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?..... | | | Barbiturates..... | | |
| 6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?..... | | | Aspirin..... | | |
| 7. Do you use tobacco?..... | | | Sedatives..... | | |
| 8. Do you use controlled substances?..... | | | Iodine..... | | |
| 9. Do you have or have you had any of the following?
Please mark all that apply: | | | Any Metals (e.g. nickel, mercury, etc.)..... | | |
| | | | Latex Rubber..... | | |
| | | | Other (please list) _____ | | |
| | | | 11. Do you have a persistent cough or throat clearing lasting more than 3 weeks?..... | | |
| | | | 12. Women only: | | |
| | | | a) Are you pregnant?..... | | |
| | | | b) Are you nursing?..... | | |
| | | | c) Are you taking contraceptives?..... | | |

- | | | | | |
|---------------------------|-------------------|--------------------|-----------------|-----------|
| High Blood Pressure | Heart Disease | Chest Pains | Heart Attack | Pacemaker |
| Easily Winded | Rheumatic Fever | Heart Murmur | Swollen Ankles | Stroke |
| Hay Fever/Allergies | Fainting/Seizures | Frequently Tired | Tuberculosis | Angina |
| Low Blood Pressure | Anemia | Radiation Therapy | Emphysema | Asthma |
| Recent Weight Loss | Glaucoma | Convulsions | Cancer | Leukemia |
| Arthritis | Liver Disease | Diabetes | Heart Trouble | AIDS/HIV |
| Joint Replacement/Implant | Kidney Diseases | Hepatitis/Jaundice | Thyroid Problem | STD's |
| Respiratory Problems | Stomach Troubles | Other _____ | | |

DENTAL HISTORY

Name of Previous Dentist: _____

- | | Yes | No | | Yes | No |
|-------------------------------------------------------------------------|-----|----|-------------------------------------------------------------------------------------|-----|----|
| 1. Do your gums bleed while brushing or flossing?..... | | | 8. Do you have frequent headaches?..... | | |
| 2. Are your teeth sensitive to hot or cold liquids/foods?..... | | | 9. Do you clench or grind your teeth?..... | | |
| 3. Are your teeth sensitive to sweet or sour liquids/foods?..... | | | 10. Do you bite your lips or cheeks frequently? | | |
| 4. Do you feel pain to any of your teeth?..... | | | 11. Have you ever had any difficult extractions in the past?..... | | |
| 5. Do you have any sores or lumps in or near your mouth?..... | | | 12. Have you ever had any prolonged bleeding following extractions?..... | | |
| 6. Have you had any head, neck, or jaw injuries?..... | | | 13. Have you had any orthodontic treatment?.. | | |
| 7. Have you ever experienced any of the following problems in your jaw? | | | 14. Do you wear dentures or partials?..... | | |
| Clicking..... | | | If yes, date of placement _____ | | |
| Pain (joint, ear, side of face)..... | | | 15. Have you ever received oral hygiene instructions regarding tooth/gum care?..... | | |
| Difficulty in opening or closing..... | | | | | |
| Difficulty in chewing..... | | | | | |

AUTHORIZATION AND RELEASE

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient’s dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. **I also understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am ultimately responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made.** I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me, if I have paid the dental fees incurred. I further understand that a late charge may be added to any overdue balance. If legal action becomes necessary to collect fees due to the office, the undersigned agrees to pay all reasonable costs of such action including attorney’s fees and collection costs and interest of 1.5% per month (18% per annum) on the unpaid balance 60 days from the treatment. **There may be a broken appointment fee of \$75/hour if a hour notice is not given to reschedule or cancel an appointment.**

Patient/Guardian Signature (Consent) _____

Date _____

FOR OFFICE USE ONLY:

Baseline Vitals: _____

Heart Rate: _____

Blood Pressure: _____

Initials: _____