

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
 EMPLOYER LAST FIRST MIDDLE OCCUPATION ()
 SOC. SEC. # BIRTHDATE NO. YEARS EMPLOYED
 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	*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:(16 Small Films or Panoramic)				For what?								
Are you having PROBLEMS now?		<input type="checkbox"/>	<input type="checkbox"/>	What MEDICATIONS are you currently taking?								
WHAT?												
Is your present dental health POOR?		<input type="checkbox"/>	<input type="checkbox"/>	Have you ever taken Fen-Phen/Redux?			<input type="checkbox"/>	<input type="checkbox"/>				
Do you wear DENTURES? (Partials or Full)		<input type="checkbox"/>	<input type="checkbox"/>	Are you PREGNANT?			<input type="checkbox"/>	<input type="checkbox"/>				
Are you UNHAPPY with your dentures?		<input type="checkbox"/>	<input type="checkbox"/>	Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)			<input type="checkbox"/>	<input type="checkbox"/>				
Would you like to know more about PERMANENT REPLACEMENTS?		<input type="checkbox"/>	<input type="checkbox"/>	PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:								
Are you APPREHENSIVE about dental treatment?		<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Pos.	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any PERIODONTAL (GUM) treatments?		<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Food allergies	<input type="checkbox"/>	<input type="checkbox"/>	Rapid weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums BLEED, or feel TENDER or IRRITATED?		<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)		<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (Rheumatism)	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with the APPEARANCE of your teeth?		<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of GRINDING or CLENCHING your teeth?		<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Do you have HEADACHES, EARACHES, or NECK PAINS?		<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Abnormal bleeding)	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Have you worn BRACES on your teeth (ORTHODONTICS)?		<input type="checkbox"/>	<input type="checkbox"/>	Atopic (Allergy Prone)	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Do you have DISCOLORED teeth that bother you?		<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your smile to LOOK BETTER or DIFFERENT?		<input type="checkbox"/>	<input type="checkbox"/>	Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Do you REGULARLY use DENTAL FLOSS?		<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Surgical implant	<input type="checkbox"/>	<input type="checkbox"/>
Name of Previous Dentist:				Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>
City:				Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease or malfunction	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease or malfunction	<input type="checkbox"/>	<input type="checkbox"/>
State:				Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco habit	<input type="checkbox"/>	<input type="checkbox"/>
How do you feel about your teeth?				Corticisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	Material allergies	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.				Cough (persistent)	<input type="checkbox"/>	<input type="checkbox"/>	(latex, wool, metal, chemicals)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
FEAR of pain #				Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer/Colitis	<input type="checkbox"/>	<input type="checkbox"/>
LACK of concern #				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Nervous problems	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
COST of treatment #				Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/heart surgery	<input type="checkbox"/>	<input type="checkbox"/>			
MISSING work time #												
				ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?								
				Aspirin	<input type="checkbox"/>	Local Anesthetic	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	Latex (balloons, gloves, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
				Nitrous Oxide	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>			
				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	<u> </u>	PHONE	<u> </u>	E-MAIL	<u> </u>			