DATE: HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

NAME: Last First MI Sex: M F O Birthdate / / ADDRESS: CITY STATE ZIP CODE

Name of closest relative or friend to contact in the event of and emergency? Phone #

|  |  |  |  |
| --- | --- | --- | --- |
| Home # | Business# |  | Cell# |
| Social Security Number |  | Single/Married | Name of Spouse |
| How would you like to be addressed? |  | E-MAIL ADDRESS |  |
| Employer |  | Occupation |  |

Whom may we thank for referring you to us?

INSURANCE INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| PRIMARY Policy Holder | Birthdate | / / | Social Security/Member ID |
| Employer | Group # |  |  |

Insurance Carrier Claims Address

SECONDARY Policy Holder

Birthdate / / Social Security/Member ID



Employer Group #

Insurance Carrier Claims Address

|  |  |
| --- | --- |
| MEDICAL HISTORY  THE FOLLOWING INFORMATION IS NECESSARY FOR YOUR DENTAL TREATMENT. YOUR ANWSERS ARE CONFIDENTIAL | |
| YES NO | YES NO |
| Do you have any CURRENT HEALTH PROBLEMS? | Are you pregnant? |
| Are you under a PHYSICIAN'S CARE now? | Are you nursing? |
| For what? Physician's Name and Phone # | What medications are you currently taking? |
| Do you use cigars/cigarettes, pipe or chewing tobacco? circle | Have you been COVID vaccinated? |
| Are you taking any of the following? | Are you Allergic or have you reacted Adversely to the follow? |
| Antibiotics or Sulfa Drugs | Local Anesthetic |
| Anticoagulants (Blood Thinners) | Aspirin |
| Medicine for High Blood Pressure | Penicillin |
| Cortisone (Steroids) | Other Antibiotics-Please List |
| Tranquilizers or Antidepressants | Iodine |
| Antihistamines | Sulfa Drugs |
| Aspirin | Codeine |
| Insulin, Tolbutamide(Orinase) or Similar Drug | Other Narcotics-Please List |
| Digitalis or Drugs for Heart Trouble | Barbiturates |
| Nitroglycerin | Sedatives |
| Oral Contraceptive or Other Hormone Therapy | Sleeping Pills |
| Other-Please List | Latex |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Please check the appropriate box, if you HAVE NOW or HAVE HAD in the past any of the following diseases or problems. | | | | | | |
| Aids/HIV positive | YES | NO | Cough up Blood | YES | NO | YES NO  Material Allergies (metal, chemicals) |
| Anemia |  |  | Diabetes |  |  | Mitral Valve Prolapse |
| Arthritis (Rheumatism) |  |  | Epilepsy |  |  | Nervous Problems |
| Artificial Joints |  |  | Fainting |  |  | Pacemaker |
| Artificial or Damaged Heart Valves |  |  | Food Allergies |  |  | Radiation Treatment |
| Asthma or Hay Fever |  |  | Headaches |  |  | Respiratory Disease |
| Autoimmune Disease/Lupus/Sjogren's |  |  | Heart Murmur |  |  | Rheumatic/Scarlet Fever |
| Back Problems |  |  | Heart Problems (please describe) |  |  | Shingles |
| Blood Disease |  |  |  |  |  | Stroke |
| Blood Transfusion |  |  | Hemophilia (abnormal bleeding) |  |  | Surgical Implant |
| Bruise Easily |  |  | Hepatitis |  |  | Swelling of Feet or Ankles |
| Cancer (internal or external) |  |  | Herpes |  |  | Thyroid Disease or Malfunction |
| Chemical Dependency |  |  | High/Low Blood Pressure |  |  | Tuberculosis |
| Chemotherapy |  |  | Kidney Disease or Malfunction |  |  | Ulcers/Colitis |
| Circulatory Problems |  |  | Liver Disease |  |  | Venereal Disease |
| Cough (Persistent) |  |  |  |  |  |  |

Do you have any disease, condition, or problem not listed above that you think we should know about? YES/NO

If yes, please explain.

DENTAL HISTORY

How long since you have seen a dentist? Chief oral complaint?

Any previous major dental treatment or oral maxillofacial surgery? YES/NO If yes, please explain?

It is important that we know about your 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.

Do you HAVE or do you USE any of the following?

YES NO YES NO YES NO

Unfavorable Dental Experience Do you have Bad Breath? Have you worn braces? (Orthodontics) Apprehensive about Dental Treatment Burning of Tongue Are you interested in Invisalign? Jaw Pain Swelling or Lumps in the Mouth Have you had Periodontal Unusual sound in ear while eating Frequent Blisters on Lips or Mouth (Gum) Treatment?



Difficulty in Opening or Closing Dry Mouth or Eyes Do your gums Bleed?

Clenching or Grinding Mouth Breathing Are your Gums Tender or Irritated? Head, Neck or Jaw Injury/Surgery Food impaction between teeth Do you have discolored teeth Frequent Headaches, Ear or Neck Pain Sensitive Teeth that bother you?

Oral Habits (fingernail or cheek biting) Cold, Hot, Sweets and Pressure (circle) Are you interested in Bleaching Are you unhappy with the appearance of your teeth? or Cosmetic Treatment?



Please Circle

Frequency of brushing 1X 2X 3X MORE (Each Day) Texture of your tooth brush? SOFT MEDIUM HARD Frequency of Flossing? 1X DAY 1X WEEK X WEEK

I certify that I have read and understand the above; I acknowledge that my questions, if any, about set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I have made in the the completion of this form.

Signature of Patient, Parent or Guardian X Date: