REGISTRATION AND HEALTH HISTORY

Date ____/____/____ Chart # _____

PERSONAL INFORMATION

Name _____
Last First Initial

SSN ___ ___ _____ Birthdate ____/____/____ Your Email _____
Mo. Day Yr.

Local Address _____
Street City State Zip Code

Other Address _____
Street City State Zip Code

Home Phone _____ Cell Phone _____

Occupation _____ Place of Employment _____ Work Phone _____

Sex _____ Height _____ Weight _____ Marital Status _____

Spouse's Name _____ Contact Phone _____

Driver's License: State _____ Number _____

Referred By _____

Do You Have Dental Insurance? No ___ Yes ___ Insurance Company _____

Policy Holder: Self ___ Spouse ___ Other (Specify) _____ SSN ___ ___ _____

Group Number _____ Insurance Co. Address _____

Group Plan _____ Phone # _____ Member/Sub ID # _____

Previous Dentist _____ City _____

Phone _____ Last seen (Year) _____

In Case Of Emergency Call _____ Phone _____

OVER →

MEDICAL INFORMATION

YES	NO	
		1. Are you allergic to any medications?
		2. Have you been seriously ill in the last five years?
		3. Have you ever been hospitalized or had a serious illness? _____
		4. Do you need premedication for dental treatment?

DO YOU HAVE OR HAVE YOU HAD?

YES	NO	
		5. Auto Immune Disorders
		6. Allergies _____
		7. Anemia
		8. Arthritis/Rheumatism
		9. Asthma/Hay Fever
		10. Bleeding Problems Type _____
		11. Blood Disease
		12. Blood Transfusion/Date _____ Reason _____
		13. Cancer or Tumor Type/Date _____
		14. Head Injury
		15. Heart Trouble/Murmur/Mitral Valve Prolapse (Circle)
		16. Heart Attack/Date _____
		17. Hepatitis (Jaundice) Type _____
		18. High/Low Blood Pressure (circle)
		19. Hives Or Skin Rash
		20. Kidney Disease
		21. Liver Disease
		22. Prosthetic Device/Date _____ Location _____
		23. Psychological Problems/Depression List _____
		24. Osteoporosis Treatment/List _____
		25. Chemotherapy Location _____
		26. Chest Pains (Angina)/Frequency _____
		27. Cortisone/Steroids
		28. Diabetes (Sugar Disease) Type: _____ Avg Daily Blood Sugar: _____ Last A1C: _____
		29. Drug Addiction
		30. Drug Reaction/Type _____
		31. Epilepsy (Seizures)
		32. Fainting (Frequent)
		33. Headaches (Frequent)
		34. Radiation For Head/Neck Cancer
		35. Rheumatic Fever/Rheumatic Heart Disease
		36. Shortness of Breath
		37. Sinus Trouble
		38. Stomach/Intestinal Disease (Ulcers)
		39. Stroke/If yes, when _____
		40. Swelling Of Hands Or Feet
		41. Thyroid Disease
		42. Tuberculosis/Lung Disease
		43. Do you have any OTHER medical condition that I should know about? _____

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS CURRENTLY:

YES	NO	
		44. Antibiotics (Penicillin, etc.) List: _____
		45. Anticoagulants (Blood Thinners, Vitamin E) Last INR _____ Date _____
		46. Antihistamines (Benadryl, etc.) Date _____
		47. Aspirin (Advil, Nuprin, etc.)
		48. Cortisone (Steroids)
		49. Digitalis (Heart Medications)
		50. Bisphosphonates (For Example: Prolia, Boniva, Fosamax)
		51. Insulin (Diabetes Medication)
		52. High Blood Pressure Medication List _____
		53. Nitroglycerin
		54. Sulfa Drugs
		55. Tranquilizers
		56. LIST ALL MEDICATIONS TAKEN _____

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO:

YES	NO	
		57. Antibiotics (Penicillin, etc.) List: _____
		58. Barbiturates (Sedatives or Sleeping Pills)
		59. Iodine
		60. Latex
		61. Local Anesthetics List: _____
		62. Narcotics (Codeine, etc.) List: _____
		63. Sulfa Drugs
		64. OTHER _____

YES	NO	
		Women only:
		65. Are you pregnant? What month?
		66. Are you taking birth control pills?
		67. Are you in or have your been through menopause?

DENTAL INFORMATION

DO YOU:

YES	NO	
		66. Have any dental pain or problems now?
		67. Fear the dentist or dental treatment?
		68. Grind or frequently clench your teeth?
		69. Have pain opening/closing your mouth?
		70. Have an unpleasant taste in your mouth?
		71. Have gums which bleed when brushing or flossing?
		72. Brush your teeth at least twice per day?
		73. Floss your teeth at least once per day?
		74. Use any tobacco products?
		75. Have any OTHER dental condition that I should know about?

HAVE YOU:

YES	NO	
		76. Had problems with dental anesthesia (Novocaine)?
		77. Had prolonged bleeding after tooth extraction?
		78. Noticed any shifting of your teeth?
		79. Worn braces?
		80. Ever been told you have gum (pyorrhea, periodontal) disease?
		81. Ever had periodontal (gum) surgery?
		82. Date of most recent dental cleaning?

___/___
Mo. Year

Our dental providers are not affiliated. Each doctor is soley responsible for the care they provide.

Signature _____ Date ___/___/___

Patient or Guardian