

# HEALTH HISTORY & REGISTRATION

Patient Number \_\_\_\_\_ **A B C**

## 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 the Visit \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_ Do you have family members who may need dental care? \_\_\_\_\_

## 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 \_\_\_\_\_  
LAST FIRST MIDDLE  
 EMPLOYER \_\_\_\_\_ 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

How long has it been since you have seen a dentist?

Date of your last completed dental exam:

Date of last full mouth x-rays: (16 Small Films or Panoramic)

	Yes	No		Yes	No
Are you currently experiencing any problems?			Are your teeth sensitive to (please circle) hot cold sweets pressure		
If yes, what?			Are you aware of grinding or clenching of your teeth?		
Do you wear Dentures? (Partials or Full)			Do you have headaches, earaches or neck pains?		
Are you unhappy with your dentures?			Have you worn braces on your teeth (Orthodontics)?		
Would you like to know more about Permanent replacements?			Would you like your smile to look better or different?		
Are you apprehensive about dental treatment?			Do you regularly use dental floss?		
Have you had any Peridental Gum treatments?			How do you feel about your teeth?		
Do your gums bleed, feel tender or are irritated?					

Name of Previous Dentist: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

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## MEDICAL HISTORY

Do you have any current health issues?

What medications are you currently taking?

	Yes	No		Yes	No
Are you under a Physician's care now?			Are you pregnant?		
Do you have high blood pressure?			Have you ever taken Fen-Phen/Redux?		
Do you experience fatigue during the day and have difficulty staying awake?			Do you have trouble remembering things or paying attention during the day?		
Do you snore?			Do you feel in some way your sleep is not refreshing or restful?		
Your snoring occurs almost every night			Do you wake up at night or in the mornings with headaches?		
You or your spouse considers your snoring louder than a person talking			Your snoring is bothersome to your bed partner		
Do you use any of the following? (please circle)    cigars    cigarettes    pipe    chewing tobacco					

## PLEASE ANSWER YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

AIDS/HIV Pos.			High blood pressure		
Anaphylaxis			Jaw pain		
Anemia			Kidney disease or malfunction		
Arthritis (Rheumatism)			Liver disease		
Artificial joints			Mitral valve prolapse		
Asthma			Nervous problems		
Atopic (Allergy Prone)			Psychiatric care		
Back problems			Rapid weight gain/loss		
Blood disease			Radiation treatment		
Cancer			Respiratory disease		
Chemical dependency			Rheumatic/scarlet fever		
Chemotherapy			Shingles		
Circulatory problems			Shortness of breath		
Cortisone treatments			Skin rash		
Cough (persistent)			Spina Bifida		
Cough up blood			Stroke		
Diabetes			Surgical implant		
Epilepsy			Swelling of feet or ankles		
Fainting			Thyroid disease or malfunction		
Food allergies			Tobacco habit		
Glaucoma			Tonsillitis		
Headaches			Tuberculosis		
Hemophilia (Abnormal bleeding)			Ulcer/Colitis		
Herpes			Venereal disease		
Hepatitis					

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PLEASE ANSWER YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:					
	Yes	No		Yes	No
HEART PROBLEMS					
Please Describe					
Artificial heart valves			Pacemaker		
Heart Surgery			Heart Murmur		

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?					
Aspirin			Codeine		
Local Anesthetic			Penicillin		
Erythromycin			Material allergies (latex wool, metal, chemicals)		
Nitrous Oxide					
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					
Phone					

Patient Signature (Parent of Child): \_\_\_\_\_ Date: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_ Date: \_\_\_\_\_