HEALTH HISTORY & REGISTRATION

Patient Information

TODAY'S DATE_____

PATIENT'S NAME: Last_____First_____MI_____Sex M F Birthdate_____ Age____

Soc. Sec #_____If Patient is a Minor Parent/Guardian's Name_____

Reason for this Visit_____ E-mail Address _____

RESPONSIBLE PARTY INFORMATION

NAME: Last_____First_____MI_____ Marital Status_____

RESIDENCE: Street_____Apt#_____City_____State_____Zip_____

MAILING ADDRESS Street_____Apt#_____City_____State_____Zip_____

Home Phone _____Cell Phone _____Work Phone_____

Soc. Sec #_____ Birthdate _____ Driver's License # _____Relation to Patient_____

Employer_____Occupation_____

Name of Dental Insurance _____Insured's Name_____

Insured's Soc. Sec #_____Insured's Birthdate_____ Insured's Employer_____

Subscriber ID # _____ Group #_____

RESPONSIBLE PARTY'S SPOUSE

Name_____

Employer_____

Occupation_____

Birthdate_____

Work Phone_____

Cell Phone_____

Home Phone_____

EMERGENCY CONTACT

Name_____

Relationship_____

Address_____

City _____State_____

Home Phone_____

Cell Phone_____

Work Phone_____

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I 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 still fully 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 will be added to any overdue balance. I understand where appropriate credit reports may be obtained.

Patient/Parent Signature_____ Date_____ Dentist Signature_____

Patient Name _____

DENTAL HISTORY

How long since you have seen a dentist? _____

Date of last complete dental exam? _____. Date of last full mouth or panoramic x-ray? _____

Are you having problems now? Y N Please describe _____

Have you had any Periodontal (gum) treatments _____ When? _____

Name of previous dentist _____

MEDICAL HISTORY

Do you have any current health problems? _____

Are under a physician's care Y N For What? _____

List all your current medications, vitamins & supplements that you are taking_____

_____

Are you Pregnant? Y N Due Date _____ Have you ever been treated for osteoporosis? Y N

Are you on or ever taken medications for osteoporosis? Y N Name of medication _____ Last taken _____

Do you take a pre-med? Y N

Are you on any type of blood thinning medication? _____ (aspirin, fish oil, plavix, coumadin, heparin (warfarin), pradaxa)

Do you use or have you used in the past: cigars, cigarettes, pipe or chewing tobacco? (Please Circle)

Is there any other Medical or Dental information that you feel I should know? _____

Family Physician_____Phone_____

Please check yes or no, of the following which have you had or do you presently have:

AIDS/HIV	Y N	EPILEPSY	Y N	OSTEOPOROSIS	Y N
ANAPHYLAXIS	Y N	FAINTING/ DIZZY / VERTIGO	Y N	PACEMAKER - TYPE_____	Y N
ANEMIA	Y N	FOOD ALLERGIES	Y N	PARKINSON'S	Y N
Anxiety	Y N	GERD / GI	Y N	PSYCHIATRIC CARE	YN
ARTHRITIS (RHEUMATISM)	Y N	GLAUCOMA	Y N	RAPID WEIGHT GAIN/LOSS	Y N
ARTIFICAL HEART VALVES	Y N	HEADACHES	Y N	RADIATION THERAPY	Y N
ARTIFICAL JOINTS _____	Y N	HEART MURMUR	Y N	REPIRATORY DISEASE	Y N
ALZHEIMERS/DEMENTIA	Y N	HEART PROBLEMS	Y N	REUMATIC/SCARLET FEVER	Y N
ASTHMA	Y N	Please describe _____		SHINGLES	Y N
ATOPIC (ALLERGY PRONE)	Y N	HEART SURGERY	Y N	SHORTNESS OF BREATH	Y N
BACK PROBLEMS	Y N	HEMOPHILIA	Y N	SKIN RASH	Y N
BLOOD DISEASE	Y N	HEPATITIS	Y N	SPINA BIFIDA	Y N
CANCER _____	Y N	HERPES	Y N	STROKE	Y N
CHEMICAL DEPENDENCY	Y N	HIGH BLOOD PRESSURE	Y N	SURGICAL IMPLANT	Y N
CHEOMTHERAPY	Y N	INSULIN PUMP	Y N	SWELLING OF FEET	Y N
CIRCULATORY PROBLEMS	Y N	JAW PAIN	Y N	THYROID DISEASE	Y N
CORTISONE TREATMENTS	Y N	KIDNEY DISEASE	Y N	TOBACCO HABIT	Y N
COUGH (PERSISTANT)	Y N	LIVER DISEASE	Y N	TONSILLITIS	Y N
COUGH UP BLOOD	Y N	MATERIAL ALLERGIES	Y N	TUBERCULOSIS	Y N
COVID	Y N	(latex, chemicals, metal, wood)		UCLCER/COLITIS	Y N
DEPRESSION	Y N	MITRAL VALVE PROLAPSE	Y N	VENERAL DISEASE	Y N
DIABETES TYPE 1 / TYPE 2	Y N	MULTIPLE SCLEROSIS	Y N		

ARE YOU ALLERGIC TO OR HAVE YOU EVER REACTED ADVERSLY TO ANY OF THE FOLLOWING?

ASPIRIN	LOCAL ANSETHETIC	ERTHROMYCIN	LATEX (balloons, gloves, etc.)
NITROUS OXIDE	CODIENE	PENICILLIN	SULFA

Please list any other medications or substances that you are allergic to: _____

Patient/Guardian Signature_____Date_____ Doctor Signature_____