HEALTH HISTORY & REGISTRATION UPDATE

Patient Information

Today's Date_____

Patient's Name: Last _____First_____ MI_____ Sex M F Birthdate_____ Age_____

Home Phone_____ Cell Phone _____ Work Phone _____

Social Security # _____ If Patient is a Minor, Parent/Guardian Name _____

Reason for this Visit _____

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 _____

Social Security # _____ Birthdate _____ Relation to Patient _____

Medical History

Do you have any current health problems? _____

Are you under a physician's care? _____for what? _____
What Medications are you currently taking? _____
Have you ever taken Fen-Phen /Redux? _____ Are you Pregnant? _____Due Date? _____
Do you use any tobacco products? _____ If yes what? _____ Do you Vape? _____
Is there any other Medical or Dental information that you feel I should know about? _____
Family Physician? _____ Phone _____

Please circle any of the following which you currently have or had in the past:

AIDS/HIV	Fainting	Psychiatric Care
Anaphylaxis	Food allergies _____	Rapid Weight Gain/ Loss
Anemia	Glaucoma	Radiation Treatments
Arthritis (Rheumatism)	Headaches	Respiratory Disease
Artificial heart valve	Heart murmur	Rheumatic Fever/Scarlett Fever
Artificial joints	Heart Problems please describe _____	Shingles
Asthma	Hemophilia	Shortness of Breath
Atopic (allergy prone)	Herpes	Skin Rash
Back Problems	Hepatitis	Spina Bifida
Blood Disease	High Blood Pressure	Stroke
Cancer	Jaw Pain	Surgical Implant
Chemical dependency	Kidney Disease	Swelling of Feet
Chemotherapy	Liver Disease	Thyroid Disease
Circulatory problems	Material Allergies _____	Tobacco Habit
Cortisone treatments	Mitral Valve Prolapse	Tonsillitis
Cough (persistent)	Nervous Problems	Tuberculosis
Cough up blood	Heart surgery	Venereal Disease
Diabetes Type 1/ Type2	Pacemaker/ Type _____	
Insulin Pump	Epilepsy_____	

Are you allergic to or you reacted adversely to any of the following medications?

Aspirin	Local Anesthetic	Erythromycin	Latex
Nitrous Oxide	Codeine	Penicillin	Sulfa

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 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 that where appropriate credit reports may be obtained.

Patient/Parent/Guardian Signature _____Date _____

Dentist Signature _____