

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 INFORMATION:
RELATIVE NOT LIVING WITH YOU**

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

Patient/Guardian Signature _____ Date _____ Doctor Signature _____