REGISTRATION & HEALTH HISTORY

PATIENT INFORMATION

Today's Date: _____

Name: _____
FIRST M.I. LAST MR. / MRS. / MS. / MISS / DR. / ETC.

__ Single __ Married __ Divorced __ Widowed __ Separated

I preferred to be called: _____ __ Male __ Female

Home Address: _____

_____

Birthdate: ___ / ___ / ___ Age: _____ S. S. # ___ / ____ / ____

Home #: ( ) _____

Work #: ( ) _____ Ext. _____

Driver's License #: _____

Employer: _____

Employer's Address: _____

_____

How long there? _____ Occupation: _____

Where & when are the best times to reach you? _____

Other family members seen by us: _____

Previous Dentist: _____

Last Dental Visit: _____

RESPONSIBLE PARTY

Name: _____
FIRST M.I. LAST MR. / MRS. / MS. / MISS / DR. / ETC.

Billing Address: _____

_____

Work #: ( ) _____ Ext. _____

Birthdate: ___ / ___ / ___ S. S. # _____ / _____ / _____

Relationship: _____ Driver's License #: _____

Employer: _____

Employer's Address: _____

_____

REFERRAL

WHO MAY WE THANK FOR REFERRING YOU TO THE OFFICE?

_____

_____

DENTAL ASSISTANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Insured's Name: _____ Relation: _____

Birthdate: ___ / ___ / ___ Age: _____ S. S. # ___ / ____ / ____

Insured's Employer: _____

Employer's Address: _____ Group # _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Insured's Name: _____ Relation: _____

Birthdate: ___ / ___ / ___ Age: _____ S. S. # ___ / ____ / ____

Insured's Employer: _____

EMERGENCY INFORMATION

In the event of an emergency is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Phone #: _____ Cell #: _____

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

_____

Are you currently in pain? _____ Yes _____ No

Date of last complete dental exam? _____

Date of last full month x-rays? _____

Have you had a serious / difficult problem with any previous dental work? _____

Your current dental health is: Good Fair Poor

Do you like your smile? _____ Yes _____ No

Do your gums bleed? _____ Yes _____ No

How many times a week do you floss? _____

MEDICAL HISTORY

Do you have a personal Physician? _____ Yes _____ No
Physician's Name: _____
Phone #: _____ Date of last visit: _____
Your current health is: Good Fair Poor
Are you under the care of a physician? _____ Yes _____ No
Please explain: _____
Are you taking any prescription drugs? _____ Yes _____ No
Alternative Medications? _____ Yes _____ No
Please list: _____
_____
Are you taking any over-the-counter drugs/herbs/diet pills?
Please list: _____
Have you ever taken any diet pills? _____ Yes _____ No
Smoking history: _____ Current _____ Past _____ Never
FOR WOMEN:
Are you taking birth control pills? _____ No _____ Yes
Are you pregnant? _____ No _____ Yes Week # _____
Are you Nursing? _____ No _____ Yes

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWNG? (PLEASE CIRCLE)

Heart attack / Stroke	Cancer / Chemotherapy
High / Low blood pressure	Diabetes / Tubercolosis TB
Heart murmur	Epilepsy / Seizures / Fainting
Rheumatic fever	Sever / Frequent headaches
Heart surgery / Pacemaker	Drug addiction / alcohol abuse
Congenital heart defect	Psychiatric problems
Artificial bones / Joints	Venereal Disease
Blood transfusion	Hemophilia / Abnormal bleeding
HIV + / AIDS	Ulcers / Colitis
Hepatitis	Anemia / Radiation treatment
Liver Disease	Difficulty breathing
Kidney problems	Emphysema / Glaucoma
Asthma / Arthritis	Thyroid Disease
Sinus problems	Fever blisters / Hay fever
Mitral Valve Prolapse	Cosmetic Surgery / Cortisone
Prosthetis	Joint Replacement
	Joint

Please list any other medical condition(s) that you have had:
_____
_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?
(PLEASE CIRCLE)

Penicillin	Tetracycline	Ibuprofen (Advil)	
Aspirin	Dental Anesthetics	Tylenol	
Erythromycin	Codeine	Latex	Jewelry

MEDICAL HISTORY

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any change in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during the diagnosis and treatment, therapy and medicines that may be indicated. I understand the use of anaesthetic is my request. I also understand that my dental insurance is a contract between the insurance carrier and myself, and not a contract between the insurance carrier and the Doctor. I understand that I am still fully responsible for all dental fees. I understand these fees are due and payable at the time services are rendered unless a prior financial arrangement has been made. I 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 feels incurred. I understand a charge may be incurred for any broken or cancelled appointment without forty-eight hour work-day notice. I also understand a late charge may be added to any overdue balance.

_____ _____
Patient / Guardian Signature Date

THANK YOU for filling out this form completely. It will help enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

OFFICIAL USE:
B.P. _____
Medical Clearance: _____ No _____ Yes _____ Received
Premdication: _____ No _____ Yes
_____
C.C. _____
_____
_____
_____
_____
_____
Signature: _____ Date: _____