

REGISTRATION & HEALTH HISTORY

PATIENT INFORMATION

Today's Date: _____

Name: _____

First M Last

Single Married Divorced Widowed Separated

I prefer to be called: _____.

Male Female

Home Address: _____

City State Zip Code

Birthdate: ____/____/____ Age: _____

S.S.#: ____/____/____

Home#: () _____

Cell#: () _____

Work#: () _____ Ext: _____

Preferred Form of Contact: Home or Cell

Email: _____

Employer: _____

Preferred Pharmacy: _____

City State Zip Code

Phone #: () _____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip Code

Insurance Co. Phone#: () _____

Insured's Name: _____ Relation: _____

Birthdate: ____/____/____ S.S.#: ____/____/____

Insured's Employer: _____

Employer's Address: _____

City State Zip Code

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip Code

Insurance Co. Phone#: () _____

Insured's Name: _____ Relation: _____

Birthdate: ____/____/____ S.S.#: ____/____/____

Insured's Employer: _____

RESPONSIBLE PARTY

Name: _____

First M Last

Billing Address: _____

City State Zip Code

Home#: () _____

Cell#: () _____

Preferred Form of Contact: Home or Cell

REFERRAL

Who may we thank for referring you to the office?

EMERGENCY INFORMATION

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

Name: _____ Relation: _____

Home#: () _____ Cell#: () _____

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Date of last dental exam? _____

Date of last full mouth x-rays? _____

Any serious/difficult problem with previous dental work? _____

Current dental health is: Good Fair Poor

Do your gums bleed? Yes No

How many times a week do you floss? _____

Medical History

Are you under the care of a physician? ___ Yes ___ No

Please explain: _____.

Physician's Name: _____.

Phone #: () _____ Date of Last Visit: ___ / ___ / ___

Your current health is (circle one): Good / Fair / Poor

Are you taking any prescription medications? ___ Yes ___ No

If yes, please list: _____

_____.

Are you taking any over-the-counter drugs/herbs/diet pills? Please list: _____

_____.

Do you need to premedicate with antibiotic before any dental visit? ___ Yes ___ No

If Yes, please list: _____

Smoking history: ___ Current ___ Past ___ Never

DO YOU TAKE ANY OF THE FOLLOWING? :

- Antiresorptive Medications (Fosamax | Boniva | Reclast | Prolia | Aredia | Zometa)
- Blood Thinners (Eliquis | Pradaxa | Lovenox | Xarelto | Coumadin | Plavix | Prasugrel)

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? (Please Circle)

Penicillin | Azithromycin | Other Antibiotics | Ibuprofen | Advil | Tylenol | Dental Anesthetics |
Sulfa Drugs | Codeine or Other Narcotics | Latex or Rubber | Foods | Jewelry | Metals

Please list any other drugs that you are allergic to: _____

_____.

For Women:

Are you taking birth control or a hormonal replacement? ___ Yes ___ No

Are you pregnant? ___ Yes ___ No Week #: _____

Are you Nursing? ___ Yes ___ No

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?
(Please Circle):

- Cardiovascular Disease | Angina | Congestive Heart Failure | Heart Attack | Stroke | High Blood Pressure | Low Blood Pressure | Heart Murmur | Prosthetic Heart Valve | Heart Surgery | Pacemaker | Mitral Valve Prolapse | Rheumatic Fever
- Arthritis | Rheumatoid Arthritis | Osteoporosis | Paget's Disease
- Asthma | Bronchitis | Difficulty Breathing | Sinus Problems
- Liver Disease | Hepatitis | Jaundice | Aids or HIV Infection | Blood Transfusion
- Cancer | Chemotherapy | Radiation
- Tuberculosis | Epilepsy | Seizures | Fainting
- Psychiatric problems or Mental Health Disorder: (Please specify: _____)
- Drug Addiction | Alcohol Abuse
- Severe Headaches | Frequent Headaches | Neurological Disorder | Neck Pain | TMJ
- STD | Venereal Disease | HPV
- Hemophilia | Abnormal Bleeding | Anemia
- Ulcers | Colitis | GI Disease | GE Reflux
- Diabetes Type I | Diabetes Type II (If either are circled: What is your A1C Level? _____)
- Emphysema | Glaucoma | Thyroid Disease | Systemic Lupus Erythematosus
- Other Autoimmune Diseases: _____.
- Sleep Disorder | Persistent Snoring
- Persistent Swollen Glands in Neck/Mouth
- Eating Disorder | Malnutrition
- Artificial Joints | Joint Replacement | Prosthesis
- Hay Fever
- Kidney Problems | Liver Problems

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

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

PATIENT ACKNOWLEDGEMENT

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 diagnosis and treatment. I understand the use of anesthetic agents embodies a certain risk and the use of any anesthetic is my request. I also understand that my dental insurance is a contract between the insurance carrier and myself, and not a contract between my 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 fees incurred. I understand a charge may be incurred for any broken or canceled 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

OFFICE USE

B.P.: _____

Medical Clearance: _____ Yes _____ No

Received: _____ Yes _____ No

Premedication: _____ Yes _____ No

C.C. _____

_____.

Signature: _____

Date: _____