# Registration and Health History

Preferred Name: _____

**PATIENT INFORMATION** Name (last) (first) (MI) Sex: M F DOB: / /

Age: SSN: Home #: Work #: Cell #:

Address: City: State: Zip: How did you hear about us?

Name your immediate family member who is a patient here:

We now confirm appointments by email. **EMAIL:**

Employer:

Physician's Name:

**EMERGENCY CONTACT** Name:

Phone #: Address: City: State: Zip:

**RESPONSIBLE PARTY** (If same as Patient Information please check ❑ SAME) Name (last) (first) (MI)

Relation to patient: Residence: City: State: Zip:

Home #: Work #: Cell #:

Responsible Party Employer: Occupation: # Years Employed:

Responsible Party Insured's SSN: Responsible Party DOB:

**DENTAL INSURANCE** Insured's name: Insurance Company:

Insured's Employer:

Insured's SSN: DOB: Group #: Phone #:

**DENTAL HISTORY** It is important for us to know your dental and medical history. These facts have a direct bearing on your Dental Health and will be kept confidential.

How long since you have seen a dentist? Last complete dental examination? (date)

Name of previous dentist: City: State: Phone #:

How do you feel about your teeth? If you could change anything about your teeth, what would it be?

**Please rate the following in order of importance which would prevent you from having dental treatment: most imp. (1) - least imp. (3)**

Fear of pain # _____ Cost of treatment # _____ Missing work time #_____

| | | | | | |
|---|---|---|---|---|---|
| Are you currently having dental problems? | YES | NO | Are your teeth sensitive to hot, cold, sweet, pressure? | YES | NO |
| What are those problems? | | | Are you unhappy with the appearance of your teeth? | YES | NO |
| Do you have dry mouth? | YES | NO | Are you aware of grinding or clenching your teeth? | YES | NO |
| Do you wear dentures (partial or full)? | YES | NO | Do you have headaches, earaches, or neck pain? | YES | NO |
| Are you happy with your dentures? | YES | NO | Have you worn braces on your teeth (orthodontics)? | YES | NO |
| Are you interested in permanent replacements? | YES | NO | Do you have discolored teeth that bother you? | YES | NO |
| Are you apprehensive about dental treatment? | YES | NO | Would you like your smile to look better or different? | YES | NO |
| Have you had any periodontal (gum) treatments? | YES | NO | Do you regularly use dental floss? | YES | NO |
| Do your gums bleed, or feel tender or irritated? | YES | NO | Reason for visit: | | |
| Slow healing mouth sores? | YES | NO | | | |

## RESPONSIBILITY AND CONSENT STATEMENT

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment. These records may include study models, photographs, x-rays, and blood studies. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate. Occasionally the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment, and its fee.

Signature of Patient: Date:

Signature of Dentist: Date:

## HEALTH HISTORY

| | | | | | |
|---|---|---|---|---|---|
| Anemia | YES | NO | HIV Positive or AIDS Related Complex | YES | NO |
| Arthritis / Rheumatoid | YES | NO | Kidney Trouble or Dialysis | YES | NO |
| Asthma | YES | NO | Latex Sensitivity | YES | NO |
| Bisphosphonates for Osteoporosis? ORAL | IV | NO | Liver Disease including Jaundice | YES | NO |
| Blood Disease | YES | NO | Low Blood Pressure | YES | NO |
| Cancer | YES | NO | Are you currently Pregnant? Trimester? | YES | NO |
| Diabetes | YES | NO | Special Needs (Autism, MR, CP, ADHD) | YES | NO |
| Do you have Sleep Apnea or use C-Pap? | YES | NO | Psychosis or Anxiety Disorder | YES | NO |
| Emphysema/COPD | YES | NO | Sore/Enlarged Lymph Nodes | YES | NO |
| Epilepsy or Seizures | YES | NO | Stomach or Intestinal Problem | YES | NO |
| Eye, Ear, Nose or Throat Problem | YES | NO | Stroke | YES | NO |
| Glaucoma | YES | NO | Thyroid Disorder | YES | NO |
| Have you ever taken cortisone or steroids? | YES | NO | Tuberculosis | YES | NO |
| Hepatitis, Any Form | YES | NO | X-Ray Therapy (Head or Neck) | YES | NO |
| High Blood Pressure | YES | NO | | | |
| Do you take any weight loss medication? | Such as: | | Phentermine or Phen-fen | YES | NO |

Have you been hospitalized in the last 5 years? YES or NO

If YES, please give reason _____

Are you currently receiving care? YES or NO If YES, nature of care: _____

Do you want or need **IV Sedation?** YES or NO

Abnormal bleeding associated with previous surgery, extraction, or trauma YES or NO

Any condition that could require **pre-medication** (such as knee/hip replacement) YES or NO

Any other disease, condition, or problem not listed above that we should know about? YES or NO _____

_____

Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, damaged coronary heart valves, heart murmur, artificial heart valve) YES or NO

Mitral Valve Prolapse YES or NO If so, When_____

Have you ever had stent / bypass surgery YES or NO If so, When_____

Pacemaker YES or NO If so, When_____

Are you allergic or have you had a reaction to: Local anesthetics YES or NO Penicillin or other antibiotics YES or NO

Aspirin YES or NO Codeine, valium or sedatives YES or NO

Any other allergies to foods, medication, _____

Are you a smoker? YES or NO. If so, how much do you smoke per day? _____For How long?_____

**ARE YOU ON A BLOOD THINNER?** YES or NO If YES, name of blood thinner: _____

Who is the Doctor prescribing the blood thinner?_____

Please list any medications you are taking and what they are for: Check here if you take no medications: ☐

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____