HEALTH HISTORY & REGISTRATION

WELCOME TO OUR PRACTICE

Patients Name _____ Sex: ❑ M ❑ F

Birth Date _____ Age _____ Today's Date _____

Home Address _____ City _____ State _____ Zip _____

Please Check One: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Occupation _____ Home Phone Number _____

Your Employer _____ Work Phone _____

Your Social Security # _____ Cell Phone _____

Are you a full time student? ❑ Yes ❑ No E-mail _____

If Patient is a minor we need: Mother's Birth Date _____ Father's Birth Date _____

Name of Spouse (Parent if Minor) _____ Person Responsible For Account _____

Spouse's (Parents') Employer _____ Relationship _____ Social Security _____

Spouse's Social Security # _____ Work Phone _____

Spouse's Birth Date _____

Referred to us by _____

Reason for this visit _____

EMERGENCY INFORMATION
Name, Address & Telephone of a Relative not living with you

_____

_____

_____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insurance Co. Phone _____

Insured's Employer _____

Insured's Social Security Number _____ Policy # _____ Group# _____ Local# _____

If you have double dental Insurance coverage complete this for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insurance Co. Phone _____

Insured's Employer _____

Insured's Social Security Number _____ Policy # _____ Group# _____ Local# _____

MEDICAL HISTORY

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	❑	❑
Are you under a PHYSICIAN'S CARE now?	❑	❑

For what? _____

_____

FAMILY PHYSICIAN: PHONE:

Are you currently taking any medication?	❑	❑

If yes, what? _____

_____

Ever had a serious illness or major surgery: _____

Circle any of the following which you have had or have at present:

Heart Disease or Attack	Blood Disorders	Epilepsy or Seizures	Tuberculosis (TB)
High Blood Pressure	Sickle Cell	Fainting or Dizzy Spells	Asthma
Low Blood Pressure	Stroke	Nervousness	Hay Fever
Heart Murmur	Kidney Trouble	Psychiatric Treatment	Sinus Trouble
Rheumatic Fever	Ulcers	Glaucoma	Allergies or Hives
Congenital heart Lesions	A.I.D.S.	Radiation Treatment	Diabetes
Artificial Heart Valve	Hepatitis	Chemotherapy	Arthritis
Heart Pacemaker	Liver Disease	Cancer	Rheumatism
Heart Surgery	Blood Transfusion	Venereal Disease (Syphilis, Gonorrhea, etc.)	Cortisone Medicine
Artificial Joints (Hip, Knee)	Hemophilia		Pain in Jaw Joints
Anemia	Fever Blisters	Emphysema	None

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

Aspirin	Ibuprofen	Codeine	Penicillin	Any Metals
Nitrous Oxide	Local Anesthetic	Erythromycin	Latex	None

Are you aware of being allergic to any other medications or substances? If yes, Please list: _____

_____

Is there any other medical or dental information that you feel I should know about? _____

_____

CONSENT:

The undersigned hereby authorizes Doctor to take necessary 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 the responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

PATIENT Signature (Parent of Child)_____ Date: _____ DENTIST Signature_____