

Patient Number _____

A B C

HEALTH HISTORY & REGISTRATION**PATIENT INFORMATION**

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____
Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____
Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____
RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____
MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____
HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____
WORK PHONE _____ E-MAIL _____
PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____
SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____
EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
LAST FIRST MIDDLE
EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____
SOC. SEC. # _____ BIRTHDATE _____
HOME PH. _____ CELL PH. _____
WORK PH. _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____
ADDRESS _____ CITY, STATE _____
HOME PH. _____ CELL PH. _____
WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____
Insurance Co. _____ E-MAIL _____
Insurance Co. Address _____
Insured's Employer _____
Insured's Soc. Sec. # _____ Group # _____ Local # _____

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

Insured's Name _____
Insurance Co. _____ E-MAIL _____
Insurance Co. Address _____
Insured's Employer _____
Insured's Soc. Sec. # _____ Group # _____ Local # _____

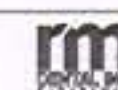
It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY		*MEDICAL HISTORY*	
YES	NO	YES	NO
HOW LONG SINCE you have seen a dentist?		Do you have any CURRENT HEALTH PROBLEMS?	
Last COMPLETE Dental Exam, Date:		Are you under a PHYSICIAN'S CARE now?	
Last FULL MOUTH X-RAYS, DATE:(16 Small Films or Panoramic)		For what?	
Are you having PROBLEMS now?		What MEDICATIONS are you currently taking?	
WHAT?			
Is your present dental health POOR?		Have you ever taken Fen-Phen/Redux?	
Do you wear DENTURES? (Partials or Full)		Are you PREGNANT?	
Are you UNHAPPY with your dentures?		Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	
Would you like to know more about PERMANENT REPLACEMENTS?		PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:	
Are you APPREHENSIVE about dental treatment?		YES NO YES NO YES NO YES NO	
Have you had any PERIODONTAL (GUM) treatments?		AIDS/HIV Pos. <input type="checkbox"/> <input type="checkbox"/> Fainting <input type="checkbox"/> <input type="checkbox"/> Psychiatric care <input type="checkbox"/> <input type="checkbox"/>	
Do your gums BLEED, or feel TENDER or IRRITATED?		Anaphylaxis <input type="checkbox"/> <input type="checkbox"/> Food allergies <input type="checkbox"/> <input type="checkbox"/> Rapid weight gain/loss <input type="checkbox"/> <input type="checkbox"/>	
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)		Anemia <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> Radiation treatment <input type="checkbox"/> <input type="checkbox"/>	
Are you UNHAPPY with the APPEARANCE of your teeth?		Arthritis (Rheumatism) <input type="checkbox"/> <input type="checkbox"/> Headaches <input type="checkbox"/> <input type="checkbox"/> Respiratory disease <input type="checkbox"/> <input type="checkbox"/>	
Are you aware of GRINDING or CLENCHING your teeth?		Artificial heart valves <input type="checkbox"/> <input type="checkbox"/> Heart murmur <input type="checkbox"/> <input type="checkbox"/> Rheumatic/scarlet fever <input type="checkbox"/> <input type="checkbox"/>	
Do you have HEADACHES, EARACHES, or NECK PAINS?		Artificial joints <input type="checkbox"/> <input type="checkbox"/> Heart problems (please describe) <input type="checkbox"/> <input type="checkbox"/> Shingles <input type="checkbox"/> <input type="checkbox"/>	
Have you worn BRACES on your teeth (ORTHODONTICS)?		Asthma <input type="checkbox"/> <input type="checkbox"/> Hemophilia (Abnormal bleeding) <input type="checkbox"/> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> <input type="checkbox"/>	
Do you have DISCOLORED teeth that bother you?		Atopic (Allergy Prone) <input type="checkbox"/> <input type="checkbox"/> Herpes <input type="checkbox"/> <input type="checkbox"/> Skin rash <input type="checkbox"/> <input type="checkbox"/>	
Would you like your smile to LOOK BETTER or DIFFERENT?		Back problems <input type="checkbox"/> <input type="checkbox"/> Hepatitis <input type="checkbox"/> <input type="checkbox"/> Spina Bifida <input type="checkbox"/> <input type="checkbox"/>	
Do you REGULARLY use DENTAL FLOSS?		Blood disease <input type="checkbox"/> <input type="checkbox"/> High blood pressure <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/>	
Name of Previous Dentist:		Cancer <input type="checkbox"/> <input type="checkbox"/> Jaw pain <input type="checkbox"/> <input type="checkbox"/> Surgical implant <input type="checkbox"/> <input type="checkbox"/>	
City: _____ State: _____		Chemical dependency <input type="checkbox"/> <input type="checkbox"/> Kidney disease or malfunction <input type="checkbox"/> <input type="checkbox"/> Swelling of feet or ankles <input type="checkbox"/> <input type="checkbox"/>	
How do you feel about your teeth?		Chemotherapy <input type="checkbox"/> <input type="checkbox"/> Liver disease <input type="checkbox"/> <input type="checkbox"/> Thyroid disease or malfunction <input type="checkbox"/> <input type="checkbox"/>	
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.		Circulatory problems <input type="checkbox"/> <input type="checkbox"/> Material allergies <input type="checkbox"/> <input type="checkbox"/> Tobacco habit <input type="checkbox"/> <input type="checkbox"/>	
FEAR of pain # _____ LACK of concern # _____		Cortisone treatments <input type="checkbox"/> <input type="checkbox"/> (latex, wool, metal, chemicals) <input type="checkbox"/> <input type="checkbox"/> Tonsillitis <input type="checkbox"/> <input type="checkbox"/>	
COST of treatment # _____ MISSING work time # _____		Cough (persistent) <input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/>	
		Cough up blood <input type="checkbox"/> <input type="checkbox"/> Nervous problems <input type="checkbox"/> <input type="checkbox"/> Ulcer/Colitis <input type="checkbox"/> <input type="checkbox"/>	
		Diabetes <input type="checkbox"/> <input type="checkbox"/> Pacemaker/heart surgery <input type="checkbox"/> <input type="checkbox"/> Venereal disease <input type="checkbox"/> <input type="checkbox"/>	
		Epilepsy <input type="checkbox"/> <input type="checkbox"/>	
		ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?	
		Aspirin _____ Local Anesthetic _____ Erythromycin _____ Latex (balloons, gloves, etc.) _____	
		Nitrous Oxide _____ Codeine _____ Penicillin _____	
		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?	
		FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____	

PATIENT Signature (Parent of Child) _____

Date: _____

DENTIST Signature _____



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