

Patient's Cell Phone _____

Patient's Email _____

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

Patient's Social Security (SS#) _____ DL # _____ County _____
 PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX M F BIRTHDATE _____ AGE _____
 If Patient is a Minor, give Parent's or Guardian's Name _____ Reason for this visit _____
 Who May We Thank for Referring You to our Office? _____ TODAY'S DATE _____

RESPONSIBLE PARTY INFORMATION

Person Who Brings in Patient
 NAME Last _____ First _____ Middle _____ MARITAL STATUS _____
 RESIDENCE Street _____ City _____ State _____ Zip _____
 HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ WORK PHONE _____ CELL PHONE _____
 PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____
 SS# _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____
 EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____
 SPOUSE'S NAME Last _____ First _____ Middle _____ WORK PHONE _____
 EMPLOYER _____ SS# _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____

EMERGENCY INFORMATION: (Person to contact in emergency)

Name _____
 Address _____
 Phone _____

(NEAREST RELATIVE NOT LIVING WITH YOU)

Name _____
 Address _____
 Phone _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____
 Insurance Company _____ Phone _____
 Insurance Co. Address _____
 Insured's Employer _____ Phone _____
 Insured's SS# _____ Group# _____ Local# _____

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

Name _____
 Insurance Company _____ Phone _____
 Insurance Co. Address _____
 Insured's Employer _____ Phone _____
 Insured's SS# _____ 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	YES	NO
HOW LONG SINCE You Have Seen A Dentist:		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, Date: Bite Wings		
Are you having PROBLEMS now?	<input type="checkbox"/>	<input type="checkbox"/>
WHAT?		
Is your present dental health POOR?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear DENTURES? (Partials or Full) Are you happy with them?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to know more about PERMANENT REPLACEMENTS?	<input type="checkbox"/>	<input type="checkbox"/>
Are you APPREHENSIVE about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any PERIODONTAL (GUM) treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums BLEED, or feel TENDER or IRRITATED?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with the APPEARANCE of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of GRINDING or CLENCHING your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have HEADACHES, EARACHES, or NECK PAIN?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your smile to LOOK BETTER or DIFFERENT?	<input type="checkbox"/>	<input type="checkbox"/>
Do you REGULARLY use DENTAL FLOSS?	<input type="checkbox"/>	<input type="checkbox"/>
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment:		
FEAR of pain # _____	LACK of concern # _____	
COST of treatment # _____	MISSING work time # _____	
CONSENT:		
<small>I the undersigned hereby authorizes Doctor to take 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 in connection with (Name of Patient) and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that 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 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I (WE) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.</small>		

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	<input type="checkbox"/>	<input type="checkbox"/>
Are you under a PHYSICIAN'S CARE now?	<input type="checkbox"/>	<input type="checkbox"/>
For what?		
What MEDICATIONS are you currently taking?		
Are you PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
Do you SMOKE?	<input type="checkbox"/>	<input type="checkbox"/>
FAMILY PHYSICIAN _____	PHONE NO. _____	
CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:		
Heart Disease or Attack	AIDS/ARC	Bruise Easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Liver Disease	Asthma
Rheumatic Fever	Blood Transfusion	Hay Fever
Congenital Heart Lesions	Drug Addiction	Sinus Trouble
Mitral Valve Prolapse	Hemophilia (Bleeding Problems)	Allergies or Hives
Artificial Heart Valve	Fever Blisters	Diabetes
Heart Pacemaker	Epilepsy or Seizures	Thyroid Disease
Heart Surgery	Nervousness	Radiation Treatment
Artificial Joints (Hip, Knee)	Psychiatric Treatment	Arthritis
Anemia	Glaucoma	Cortisone Medicine
Stroke	Chemotherapy (Cancer, Leukemia)	Pain in Jaw Joints
Kidney Trouble	Venerable Disease	Alcoholism
Ulcers	(Syphilis, Gonorrhea, etc.)	Cosmetic Surgery
ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?		
Aspirin	Local Anesthetic	Erythromycin
Nitrous Oxide	Codeine	Penicillin
Are you aware of being allergic to any other medications or substances? _____		

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 GENERAL AND COSMETIC DENTISTRY

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PATIENT Signature (Parent of Child) _____

Date _____

DENTIST Signature _____