# HEALTH HISTORY & REGISTRATION

## PATIENT INFORMATION

PATIENT'S NAME Last_____ First_____ Middle Initial_____ Sex: M F Birthdate _____Age_____

Social Security #_____If patient is a Minor, give Parent's or Guardian's Name_____ Today's Date_____

How did you hear about our office? _____Reason for Visit_____

## RESPONSIBLE PARTY INFORMATION

Name Last_____First_____Middle Intitial_____ Marital Status_____

Residence Street Address_____Apt. #._____City_____State_____Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

E-Mail Address_____ Driver's License #_____E-mail Address of Patient_____

Social Security # (of responsible party)_____Birthday_____ Relationship to Patient_____

Employer_____ Occupation_____ No. of years employed_____

### RESPONSIBLE PARTY'S SPOUSE

**NAME**_____
LAST FIRST MIDDLE

Employer_____ Occupation_____
Home phone_____Work _____Cell _____
Soc.Sec. #_____ Birthdate_____

### EMERGECY INFORMATION: RELATIVE NOT LIVING WITH YOU

**NAME**_____
LAST FIRST MIDDLE

Address_____City, State_____

Home Phone_____Cell PH._____

## DENTAL INSURANCE INFORMATION

Primary Carrier Insured's Name_____ Insurance Company_____

Insured's Employer_____ Insured Social Sec. #_____ Group Number_____

Do you have double dental insurance coverage? Y N If so: Insured's Named_____ Employer_____

Insurance Company (for second insurance)_____ Social Sec Number_____Group Number_____

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 without your permission. Thank you for taking the time to completely fill out this questionnaire.

## DENTAL HISTORY

HOW LONG SINCE you have seen a dentist? _____
Last COMPLETE Dental Exam, Date:_____
Last Full Mouth X-RAYS, Date (16 small Films or Panoramic)_____
Are your having problems now? Y, N Please Explain_____

_____

| | |
|---|---|
| Is your present dental health POOR? | Y N |
| Do you wear DENTURES?(Partials or Full)? | Y N |
| Are you APPREHENSIVE about dental treatment? | Y N |
| Have you had any PERIODONTAL (GUM) treatments? | Y N |
| Do your gums Bleed, or feel Tender or Irritated? | Y N |
| Are you sensitive to hot, cold, sweets, pressure? (circle) | Y N |
| Are you UNHAPPY with the APPEARANCE of your teeth? | Y N |

Explain _____

_____

| | |
|---|---|
| Are you aware of Grinding or Clenching your teeth | Y N |
| Do you have headaches, Earaches, or Neck Pains? | Y N |
| Have your worn BRACES on you teeth (orthodontics)? | Y N |
| Do you have Discolored teeth that bother you? | Y N |
| Would you like to have your smile Look Better or Different | Y N |
| Do you regularly use Dental Floss (at least 5x / week) | Y N |

Name of Previous or Current Dentist_____

City_____ State_____

Please rank 1 to 4 (1 being the Most) the order in which they would KEEP YOU FROM having dental treatment

FEAR of pain_#_____ Lack of concern_#_____

Cost of treatment_#_____ Missing work time_#_____

## MEDICAL HISTORY

Do you have any CURRENT HEALTH PROBLEMS? Y N
Are you under a PHYSICIAN'S CARE now? Y N
For what? _____
What Medications are you currently taking (please list) _____

_____

Do you use cigars/cigarettes, pipe or chewing tobacco? )circle Y N
Women, ARE YOU PREGNANT? Y N

***PLEASE CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE***

| | | |
|---|---|---|
| **AIDS/HIV POS.** | **Fainting** | **Psychiatric Care** |
| **Anaphylaxis** | **Food Allergies** | **Rapid weight gain/loss** |
| **Anemia** | **Glaucoma** | **Radiation Treatment** |
| **Arthritis** | **Headaches** | **Respiratory disease** |
| **Artificial Joints** | **Heart Murmur** | **Rheumatic Fever** |
| **Artificial Heart valves** | **Heart Problems (describe)** | **Shingles** |
| **Asthma** | _____ | **Shortness of Breath** |
| **Back problems** | **Hemophilia** | **Skin Rash** |
| **Blood disease** | **Herpes** | **Spina Bifida** |
| **Cancer** | **Hepatitis** | **Stroke** |
| **Chemical dependency** | **High Blood Pressure** | **Surgical Implant** |
| **Chemotherapy** | **Kidney Disease** | **Thyroid Disease** |
| **Circulatory problems** | **Liver Disease** | **Tobacco habit** |
| **Cortisone treatments** | **Material Allergies** | **Tonsilitis** |
| **Cough (persistent)** | **(latex, metal, chemicals)** | **Tuberculosis** |
| **Cough up blood** | **Mitral Valve Prolapse** | **Ulcer/ Colitis** |
| **Diabetes** | **Nervous problems** | **Venereal Disease (STD's)** |
| **Epilepsy or seizures** | **Pacemaker/heart surgery** | |

**Are you allergic or have you reacted adversely to nay of the following?**
Aspirin Local Anesthetic Erythromycin Latex Nitrous Oxide Codeine Penicillin

**Any other known allergies?** _____

**Is there any other Medical or Dental information that you feel I should know about?**

_____

**Family Physician** _____**Phone**_____

**I have filled out this chart to the best of my knowledge:**
Patient Signature (Parent of Child)_____Date_____DENTIST SIGNATURE_____