HEALTH HISTORY & REGISTRATION

Patient's Name:_____ Preferred Name:_____Sex: M F

Birthdate: _____Age: _____ Your Soc. Sec. # _____

Email Address_____

Home Address_____Zip_____

Home Number: _____ Work Number: _____ Cell Number_____ Text ☐ Yes ☐ No

Your Employer_____

Occupation_____

Name of Person Responsible for Account_____

Name of Spouse (Parent of Minor)_____

Spouse's (Parent's) Employer_____

Spouse's Soc. Sec. #_____

EMERGENCY CONTACT INFORMATION: Name, Address & Telephone of a relative not living with you:

_____

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)

Insured's Name_____DOB_____SS#_____

Insured's Employer_____

Insurance Co._____

Insurance Co. Address_____

Phone No._____

DENTAL INSURANCE INFORMATION (SECONDARY CARRIER)

Insured's Name_____DOB_____SS#_____

Insured's Employer_____

Insurance Co._____

Insurance Co. Address_____

Phone No._____

CANCELLATION POLICY

We understand that emergencies may arise that preclude you from keeping an appointment, but as our office strives to treat patients in a timely manner, we expect the courtesy to be returned. **A minimum 24 hour notification must be given to avoid a possible cancellation fee due to the inconvenience caused to the office.**

REFERRAL:

Referred to us by:_____

DENTAL HISTORY

Reason for today's visit_____

Former Dentist_____ Phone #: _____

City/State_____

Date of last dental visit_____

What is most important to you regarding your dental health:_____

How often do you floss? _____ How often do you brush? _____

Mark "yes" or "no" to indicate if you have had history of the following:

Sensitivity to cold/hot □ Yes □ No

Sensitivity to biting □ Yes □ No

Sensitivity to sweets □ Yes □ No

Grinding/clenching teeth □ Yes □No

Clicking or popping jaw □ Yes □ No

Jaw pain or tiredness □ Yes □ No

Bad breath □ Yes □ No

Lip or cheek biting □ Yes □ No

Gums swollen and tender □ Yes □ No

Blisters on lips or mouth □ Yes □ No

Mouth pain with brushing □ Yes □ No

Burning sensation on tongue □ Yes □ No

Bleeding gums □ Yes □ No

Sores or growths in mouth □ Yes □ No

Gum disease □ Yes □ No

Smoke or chew tobacco □ Yes □ No How long_____ How much_____

Have you have EVER smoked or chewed tobacco □ Yes □ No How long_____ How much_____

Periodontal (Gum) surgery □ Yes □ No

Loose or broken fillings □ Yes □ No

Dry mouth □ Yes □ No

MEDICAL HISTORY

Do you have any CURRENT HEALTH PROBLEMS? □ Yes □ No If yes, explain:_____

_____

Are you under a PHYSICIAN"S CARE now? □ Yes □ No If yes, explain:_____

_____

Physician's Name_____Phone#_____

Date of last visit_____

HEALTH HISTORY

Place a mark on "yes" or "no" to indicate if you have had history of the following:

AIDS/HIV □ Yes □ No
Anemia □ Yes □ No
Arthritis, Rheumatism □ Yes □ No
Artificial Heart Valves □ Yes □ No
Artificial Joints □ Yes □ No
Asthma □ Yes □ No
Back Problems □ Yes □ No
Blood Disease □ Yes □ No
Cancer □ Yes □ No
Chemical dependency □ Yes □ No
Cholesterol- high □ Yes □ No
Circulatory Problems □ Yes □ No
Cortisone Treatments □ Yes □ No
Depression □ Yes □ No
Diabetes □ Yes □ No
Dry mouth □ Yes □ No
Extractions or surgery □ Yes □ No
Rapid Weight gain or less □ Yes □ No
Respiratory Dx/Emphysema □ Yes □ No

Epilepsy □ Yes □ No
Fainting or dizziness □ Yes □ No
Glaucoma □ Yes □ No
Headaches- Migraine □ Yes □ No
Heart Murmur □ Yes □ No
Heart Problems □ Yes □ No
Hepatitis Type_____ □ Yes □ No
Herpes □ Yes □ No
High Blood Pressure □ Yes □ No
Chemotherapy/Radiation □ Yes □ No
Jaw Pain □ Yes □ No
Kidney Disease □ Yes □ No
Liver Disease □ Yes □ No
Low Blood Pressure □ Yes □ No
Mitral Valve Prolapse □ Yes □ No
Pregnant/Breastfeeding □ Yes □ No
Nervous Problems □ Yes □ No

Pacemaker □ Yes □ No
Rheumatic Fever □ Yes □No
Jaundice □ Yes □ No
Shortness of Breath □ Yes □ No
Sinus Trouble □ Yes □ No
Sleep Apnea □ Yes □ No
Skin Rash □ Yes □ No
Special Diet □ Yes □ No
Stroke □ Yes □ No
Swollen Feet or Ankles □ Yes □ No
Swollen Neck Glands □ Yes □ No
Thyroid Problems □ Yes □ No
Tuberculosis □ Yes □ No
Ulcer(s) □ Yes □ No
Venereal Disease □ Yes □ No
Psychiatric Care □ Yes □ No

Shingles □ Yes □ No
Scarlet Fever □ Yes □ No

Other □ Yes □ No Explain:_____

MEDICATIONS ALLERGIES/REACTIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Do you have any of the following allergies? If yes, check all:

Clindamycin □
Codeine/Vicodin □
Keflex □
Ibuprofen □
Nitrous oxide □
Local Anesthetic □
Acetaminophen □
Latex □
Valium (Diazepam) □
Penicillin □

Other_____

PATIENT Signature (or Guardian)_____Date:_____