

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 \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
 RESIDENCE Street \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 MAILING ADDRESS Street \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 HOW LONG AT THIS ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 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 \_\_\_\_\_ NO. YEARS EMPLOYED \_\_\_\_\_  
 OCCUPATION \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_  
 WORK PHONE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

### EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY, STATE \_\_\_\_\_ PHONE \_\_\_\_\_

### DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 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. \_\_\_\_\_  
 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*		YES	NO	*MEDICAL HISTORY*		YES	NO
HOW LONG SINCE you have seen a Dentist?				Do you have any CURRENT HEALTH PROBLEMS? <input type="checkbox"/> <input type="checkbox"/>			
Last COMPLETE Dental Exam, Date:				Are you under a PHYSICIAN'S CARE now? <input type="checkbox"/> <input type="checkbox"/>			
Last FULL MOUTH X-RAYS, DATE: (16 small Films or Panoramic)				For What?			
Are you having PROBLEMS now? <input type="checkbox"/> <input type="checkbox"/>				What MEDICATIONS are you currently taking?			
WHAT?				Are you PREGNANT? <input type="checkbox"/> <input type="checkbox"/>			
Is your present dental health POOR? <input type="checkbox"/> <input type="checkbox"/>				Do you use cigars/cigarettes, pipe or chewing tobacco? Circle <input type="checkbox"/> <input type="checkbox"/>			
Do you wear DENTURES? (Partials or Full) <input type="checkbox"/> <input type="checkbox"/>				<b>CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:</b>			
Are you UNHAPPY with your dentures? <input type="checkbox"/> <input type="checkbox"/>				Heart Disease or Attack		AIDS/ARC/HIV Pos.	
Would you like to know more about PERMANENT REPLACEMENTS? <input type="checkbox"/> <input type="checkbox"/>				Angina Pectoris		Hepatitis A (infectious)	
Are you APPREHENSIVE about dental treatment? <input type="checkbox"/> <input type="checkbox"/>				High Blood Pressure		Hepatitis B (serum)	
Have you had any PERIODONTAL (GUM) treatments? <input type="checkbox"/> <input type="checkbox"/>				Heart Murmur		Hepatitis C	
Do your gums BLEED, or feel TENDER or IRRITATED? <input type="checkbox"/> <input type="checkbox"/>				Rheumatic Fever		Liver Disease	
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle) <input type="checkbox"/> <input type="checkbox"/>				Congenital Heart Lesions		Blood Transfusion	
Are you UNHAPPY with the APPEARANCE of your teeth? <input type="checkbox"/> <input type="checkbox"/>				Mitral Valve Prolapse		Drug Addiction	
Are you aware of GRINDING or CLENCHING your teeth? <input type="checkbox"/> <input type="checkbox"/>				Artificial Heart Valve		Hemophilia (Bleeding Problems)	
Do you have HEADACHES, EARACHES, or NECK PAINS? <input type="checkbox"/> <input type="checkbox"/>				Heart Pacemaker		Fever Blisters	
Have you worn BRACES on your teeth? (ORTHODONTICS) <input type="checkbox"/> <input type="checkbox"/>				Heart Surgery		Epilepsy or Seizures	
Do you have DISCOLORED teeth that bother you? <input type="checkbox"/> <input type="checkbox"/>				Artificial Joints (Hip, Knee)		Nervousness	
Would you like your smile to LOOK BETTER or DIFFERENT? <input type="checkbox"/> <input type="checkbox"/>				Anemia		Psychiatric Treatment	
Do you REGULARLY use DENTAL FLOSS? <input type="checkbox"/> <input type="checkbox"/>				Stroke		Glaucoma	
Name of Previous Dentist:				Kidney Trouble		Chemotherapy (Cancer, Leukemia)	
City: _____ State: _____				Ulcers		Venereal Disease (Syphilis, Gonorrhea, etc.)	
How do you feel about your teeth?				ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING?			
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.				Aspirin _____ Local Anesthetic _____ Erythromycin _____ Latex (balloons, gloves, etc.) _____			
FEAR of pain # _____		LACK of concern # _____		Nitrous Oxide _____ Codeine _____ Penicillin _____			
COST of treatment # _____		MISSING work time # _____		Are you aware of being allergic to any other foods, medications or substances? _____			
FAMILY PHYSICIAN _____				PHONE NO. _____			

PATIENT Signature (Parent of Child) \_\_\_\_\_ Date: \_\_\_\_\_ DENTIST Signature \_\_\_\_\_

