PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (____)_____

Patient _____
Last Name First Name Middle Initial Preferred Name

Street Address _____ City_____ State _____ Zip_____

E-mail_____ Cell Phone (____) _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by_____ Occupation _____

Business Address_____ Business Phone (____)_____

Who is responsible for this account?_____ Relationship to Patient _____

Social Security #_____ Spouse/Parent's Social Security # _____

Name of Dental Insurance Company _____ Group Number_____

In case of emergency, who should be notified?_____ Phone (_____) _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical_____

Have you ever had any of the following? (check boxes that apply):

☐ Allergies	☐ Epilepsy	☐ Pacemaker
☐ Arthritis	☐ Headaches	☐ Psychiatric Care
☐ Artificial Heart Valves or Joints, Screws, etc	☐ Heart Murmur	☐ Radiation Treatment
☐ Back Problems	☐ Heart Problems	☐ Recent Weight Loss
☐ Bleeding Abnormally	☐ Hemophilia	☐ Respiratory Disease
☐ Blood Disease	☐ Hepatitis, Jaundice or Liver Disease	☐ Rheumatic Fever
☐ Cancer	☐ Hernia Repair	☐ Sinus Problems
☐ Chemical Dependency	☐ High Blood Pressure	☐ Special Diet
☐ Chronic Diarrhea	☐ HIV/AIDS	☐ Stroke
☐ Circulatory Problems	☐ Low Blood Pressure	☐ Swollen Neck Glands
☐ Congenital Heart Lesions	☐ Mitral Valve Prolapse	☐ Ulcer
☐ Diabetes	☐ Nervous Problems	☐ Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ☐ Yes ☐ No

If so, what?_____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Are you taking any medication at this time?_____ If so, what?_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Due date _____

Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

PATIENT DENTAL HISTORY

PATIENT'S NAME _____ **DATE OF BIRTH** _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN- WHEN & WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED YES ☐ NO ☐

	YES	NO
Do your gums bleed while brushing or flossing	☐	☐
Are your teeth sensitive to hot or cold liquids/foods	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods	☐	☐
Do any of your teeth feel painful	☐	☐
Do you have any sores or lumps in or near your mouth	☐	☐
Have you had any head, neck, or jaw injuries	☐	☐
Have you experienced any of the following problems		
Clicking in your jaw	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing your jaw	☐	☐
Difficulty in chewing	☐	☐
Do you have frequent headaches	☐	☐
Do you clench or grind your teeth	☐	☐

	YES	NO
Do you bite your lips or cheeks frequently	☐	☐
Have you noticed any loosening of your teeth	☐	☐
Does food tend to become caught between your teeth	☐	☐
Have you ever had periodontal treatment (gums)	☐	☐
Have you ever worn a bite plate or other appliance	☐	☐
Have you had any difficult extractions in the past	☐	☐
Have you ever had any prolonged bleeding following Extractions	☐	☐
Do you wear dentures or partials	☐	☐
If yes, give the date they were placed _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR **DATE**

_____ _____

DOCTOR'S SIGNATURE **DATE**

DOCTOR'S COMMENTS _____

PRINT FORM