DENTAL REGISTRATION AND HEALTH HISTORY

DATE_____

Patients Name_____How do you prefer to be addressed?_____

Mailing Address _____City _____ State _____ Zip _____

Sex: M F Age:_____ Birth date: _____ Single Married Widow Separated Divorced SS# _____

Home Phone Number: _____ Work Phone Number: _____

Occupation: _____ Employer: _____

Employer's Address: _____ City _____ State _____

If Student, name of School / College: _____ City _____ State _____ PT Full

Whom may we thank for referring you to our office: _____

If the person responsible for this patients account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information"

Name of responsible party _____ Relationship to Patient _____

Mailing Address _____City _____ State _____ Zip _____

Sex: M F Age:_____ Birth date: _____ Single Married Widow Separated Divorced SS# _____

Home Phone Number: _____ Work Phone Number: _____

Occupation: _____ Employer: _____

Employer's Address: _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Policy Holders Name _____ Relationship to Patient _____ SS # _____DOB _____

Name of Employer _____ Employee Address _____ State _____

Insurance Co. _____ Group # _____ Address _____

Secondary Insurance Information

Policy Holders Name _____ Relationship to Patient _____ SS # _____DOB _____

Name of Employer _____ Employee Address _____ State _____

Insurance Co. _____ Group # _____ Address _____

Answers to the following questions are for our records only and will be considered confidential.

1.	Have you or any member of your family been seen by us before? If yes, which family member (s)?_____	**Yes**	**No**
2.	Date of last physical examination _____ Physician's Name _____		
3.	Date of last dental examination _____ Date of last dental x-rays _____		
4.	Previous Dentist's name _____ City/State _____		
5.	Are you having pain or discomfort at this time?	**Yes**	**No**
6.	Do you feel nervous about having dental treatment?	**Yes**	**No**
7.	Have you ever had a bad experience in a dental office?	**Yes**	**No**
8.	Is there anything you dislike about your smile?	**Yes**	**No**
9.	Is there anything you would like to speak with the Doctor about in private?	**Yes**	**No**
10.	Have you been a patient in the hospital during the past two years?	**Yes**	**No**
11.	Have you been under the care of a medical doctor during the past two years?	**Yes**	**No**
12.	Have you taken any medications or drugs in the past two years?	**Yes**	**No**
13.	Are you taking any vitamins, herbal supplements or "cures"?	**Yes**	**No**
14.	Have you ever had any excessive bleeding requiring special treatment?	**Yes**	**No**

ALLERGIES

Aspirin
Barbiturates
Codeine
Iodine
Latex
Local Anesthetic
Penicillin
Sulfa
Metals
Other: _____

MEDICATIONS

Please list medications you are currently taking:

_____

_____

_____

Pharmacy :_____

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

Chest Pain	Yes	No	Shortness of Breath	Yes	No	Hives or skin rash	Yes	No
Heart Failure	Yes	No	Ulcers	Yes	No	Alcoholism	Yes	No
Heart Disease or Attack	Yes	No	Mental Retardation	Yes	No	Herpes	Yes	No
Angina Pectoris	Yes	No	Emphysema	Yes	No	Glaucoma	Yes	No
Heart Problems	Yes	No	Fainting or dizzy spells	Yes	No	*Steroid Treatment	Yes	No
Liver Disease	Yes	No	Eating Disorder	Yes	No	Arthritis	Yes	No
Heart Surgery	Yes	No	Epilepsy or seizures	Yes	No	*Any type of implant	Yes	No
High Blood Pressure	Yes	No	Persistent Cough	Yes	No	Dentures or Partials	Yes	No
*Heart Murmur	Yes	No	Tuberculosis (TB)	Yes	No	Birth defects	Yes	No
*Rheumatic Fever	Yes	No	Asthma	Yes	No	HIV Positive, ARC, AIDS	Yes	No
Psychiatric treatment	Yes	No	*Congenital Heart Problems	Yes	No	Hay fever	Yes	No
Sickle Cell Disease	Yes	No	Hepatitis A (Infectious)	Yes	No	Use of tobacco products	Yes	No
Sinus trouble	Yes	No	Hepatitis B (Serum)	Yes	No	Bruise easily	Yes	No
*Artificial joints	Yes	No	Hepatitis C or other	Yes	No	Jaundice	Yes	No
Thyroid Disease	Yes	No	Heart pacemaker	Yes	No	Heart Surgery	Yes	No
Anemia	Yes	No	Stroke	Yes	No	Kidney Trouble	Yes	No
Blood transfusion	Yes	No	Drug addiction	Yes	No	Hemophilia	Yes	No
*Any type of transplant	Yes	No	Cold Sores	Yes	No	Diabetes	Yes	No
*Mitral Valve Prolapse	Yes	No	Radiation Therapy	Yes	No	Chemotherapy	Yes	No
						Cancer (type:)	Yes	No

***Antibiotic pre-medication may be required prior to your appointment.**

Have you ever experienced any of the following problems with your jaw:

Clicking	Yes	No
Pain in or around your ears ?	Yes	No
Difficulty opening or closing	Yes	No
Difficulty chewing	Yes	No
Do you have a history of trauma to your jaw?	Yes	No
Have you ever been diagnosed with TMJ/TMD?	Yes	No

Do you have currently have any problems listed below?
Please circle all that apply:

Swelling Bad Taste
Bleeding Gums Loose Teeth
Sensitive to:
Hot Cold
Biting/Pressure Sweets
Other: _____

Do you have any sores, lumps or growths in or near your mouth?	Yes	No	Problem with bad breath? (Halitosis)	Yes	No
Have you ever had difficult extraction's in the past?	Yes	No	Do you have any trouble chewing?	Yes	No
Have you ever had prolonged bleeding following extraction's?	Yes	No	Does food collect between your teeth?	Yes	No
Are there now any growths or sores in or around your mouth?	Yes	No	Have you ever had instructions in oral hygiene ?	Yes	No
Do you habitually clench or grind your teeth during the day or night?	Yes	No	Have you ever taken Redux or Pondimin (Fen Phen) ?	Yes	No

Have you ever been told you have gum problems?	Yes	No
Have you ever needed to see a periodontist ?	Yes	No
Do you now have bleeding gums or any other gum condition?	Yes	No
Is there anything related to your medical or dental history that you have not indicated above ?	Yes	No

If yes, please explain: _____

WOMEN: Are you pregnant now?	Yes	No	If yes, what is your due date? _____
Are you currently breast feeding?	Yes	No	
Are you taking oral contraceptives?	Yes	No	

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 pay able 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.

X _____

Signature of patient or guardian