

Patient Number _____ A B B- C

Health History & Registration

PATIENT INFORMATION (if Minor)

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: _____
 Reason for this Visit: _____

PATIENT INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____
 RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____
 MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____
 HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____
 WORK PHONE _____ E-MAIL _____
 PREVIOUS ADDRESS (If less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____
 SOC SEC # _____ BIRTHDATE _____ DRIVERS LICENSE # _____ RELATION TO PATIENT _____
 EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

EMERGENCY CONTACT INFORMATION

NAME _____
 LAST FIRST MIDDLE
 RELATIONSHIP TO PATIENT _____
 HOME PH. _____ CELL PH. _____
 WORK PH. _____ E-MAIL _____

REFERRAL SOURCE

Whom may we thank for referring you? :
 Family Friend Co-Worker Doctor
 Name: _____
 Or did you find us on your own:
 Yellow Pages Internet _____ Mail
 Insurance Magazine _____
 Newspaper _____ Other _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name: _____
 Insurance Co.: _____ E-MAIL _____
 Insurance Co. Address: _____
 Insured's Employer: _____
 Insured's Soc Sec #: _____ Group #: _____ Local #: _____

PATIENT EMPLOYER INFORMATION

Employer Name _____
 Employer Address _____
 Employer Phone Number _____

*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 ALLERGIC to any Medications? <input type="checkbox"/> Yes _____ <input type="checkbox"/> No			
Is your present dental Health POOR?		<input type="checkbox"/>	<input type="checkbox"/>	Have you ever taken Fen-Phen/Redux?		<input type="checkbox"/>	<input type="checkbox"/>
Do you wear DENTURES? (Partials or Full?)		<input type="checkbox"/>	<input type="checkbox"/>	Are you PREGNANT?		<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with your dentures?		<input type="checkbox"/>	<input type="checkbox"/>	Do you use cigars/cigarettes, pipe, or chewing tobacco? (circle)		<input type="checkbox"/>	<input type="checkbox"/>
Would you like to know more about PERMANENT REPLACEMENT		<input type="checkbox"/>	<input type="checkbox"/>	PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:			
Are you APPREHENSIVE about dental treatment?		<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Pos.	<input type="checkbox"/> YES <input type="checkbox"/> NO	Fainting	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you had any PERIODONTAL (GUM) treatments?		<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Food Allergies	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do your gums BLEED, or feel TENDER or IRRITATED?		<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Glaucoma	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are your teeth sensitive to hot, cold sweets pressure?(circle)		<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Headaches	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you unhappy with the APPEARANCE of your teeth?		<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valves	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart murmur	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you aware of GRINDING, or CLENCHING your teeth?		<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart problems (please describe)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have HEADACHES, EARACHES, or NECK PAINS?		<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you worn BRACES on your teeth? (orthodontics)		<input type="checkbox"/>	<input type="checkbox"/>	Atopic (allergy prone)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hemophilia	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have DISCOLORED teeth that bother you?		<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Herpes	<input type="checkbox"/> YES <input type="checkbox"/> NO
Would you like your smile to LOOK BETTER or DIFFERENT?		<input type="checkbox"/>	<input type="checkbox"/>	Blood disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you REGULARLY use DENTAL FLOSS?		<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	High blood pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Name of Previous Dentist:				Chemical dependency	<input type="checkbox"/> YES <input type="checkbox"/> NO	Jaw pain	<input type="checkbox"/> YES <input type="checkbox"/> NO
City:			State:	Chemotherapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
How do you feel about your teeth?				Circulatory problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Liver disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
				Cortisone treatments	<input type="checkbox"/> YES <input type="checkbox"/> NO	Malnutrition	<input type="checkbox"/> YES <input type="checkbox"/> NO
				Cough	<input type="checkbox"/> YES <input type="checkbox"/> NO	Material allergies	<input type="checkbox"/> YES <input type="checkbox"/> NO
				Cough up blood	<input type="checkbox"/> YES <input type="checkbox"/> NO	(latex, wool, metal, chemicals)	<input type="checkbox"/> YES <input type="checkbox"/> NO
				Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mitral valve prolapse	<input type="checkbox"/> YES <input type="checkbox"/> NO
				Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Nervous problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Pacemaker/heart surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Psychiatric care	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Rapid weight gain/loss	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Radiation treatment	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Respiratory disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Rheumatic	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Shingles	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Shortness of breath	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Skin Rash	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Spina bifida	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Surgical implant	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Swelling of feet/ankles	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Thyroid disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Tobacco habit	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Tonsillitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Tuberculosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Ulcer/Colitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
						Venereal disease	<input type="checkbox"/> YES <input type="checkbox"/> NO

Family Physician: _____ Phone _____ E-mail _____

Patient Signature: _____ Date: _____ Dentist Signature: _____