

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: _____

Who May We Thank for Referring You to Our Office? _____

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 Yellow Book Billboard Mail Radio

Insurance Web Sign 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"/> No <input type="checkbox"/> Yes _____		
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"/>	YES NO YES NO YES NO		
Have you had any PERIODONTAL (GUM) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Pos. <input type="checkbox"/> <input type="checkbox"/> Fainting <input type="checkbox"/> <input type="checkbox"/> Pacemaker/heart surgery <input type="checkbox"/> <input type="checkbox"/>		
Do your gums BLEED, or feel TENDER or IRRITATED?	<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis <input type="checkbox"/> <input type="checkbox"/> Food Allergies <input type="checkbox"/> <input type="checkbox"/> Psychiatric care <input type="checkbox"/> <input type="checkbox"/>		
Are your teeth sensitive to hot, cold sweets pressure?(circle)	<input type="checkbox"/>	<input type="checkbox"/>	Anemia <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> Rapid weight gain/loss <input type="checkbox"/> <input type="checkbox"/>		
Are you unhappy with the APPEARANCE of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis <input type="checkbox"/> <input type="checkbox"/> Headaches <input type="checkbox"/> <input type="checkbox"/> Radiation treatment <input type="checkbox"/> <input type="checkbox"/>		
Are you aware of GRINDING, or CLENCHING your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valves <input type="checkbox"/> <input type="checkbox"/> Heart murmur <input type="checkbox"/> <input type="checkbox"/> Respiratory disease <input type="checkbox"/> <input type="checkbox"/>		
Do you have HEADACHES, EARACHES, or NECK PAINS?	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints <input type="checkbox"/> <input type="checkbox"/> Heart problems (please describe) _____ <input type="checkbox"/> <input type="checkbox"/> Rheumatic <input type="checkbox"/> <input type="checkbox"/>		
Have you worn BRACES on your teeth? (orthodontics)	<input type="checkbox"/>	<input type="checkbox"/>	Asthma <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> Shingles <input type="checkbox"/> <input type="checkbox"/>		
Do you have DISCOLORED teeth that bother you?	<input type="checkbox"/>	<input type="checkbox"/>	Atopic (allergy prone) <input type="checkbox"/> <input type="checkbox"/> Hemophilia <input type="checkbox"/> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> <input type="checkbox"/>		
Would you like your smile to LOOK BETTER or DIFFERENT?	<input type="checkbox"/>	<input type="checkbox"/>	Back problems <input type="checkbox"/> <input type="checkbox"/> Herpes <input type="checkbox"/> <input type="checkbox"/> Skin Rash <input type="checkbox"/> <input type="checkbox"/>		
Do you REGULARLY use DENTAL FLOSS?	<input type="checkbox"/>	<input type="checkbox"/>	Blood disease <input type="checkbox"/> <input type="checkbox"/> Hepatitis <input type="checkbox"/> <input type="checkbox"/> Spina bifida <input type="checkbox"/> <input type="checkbox"/>		
Name of Previous Dentist:			Cancer <input type="checkbox"/> <input type="checkbox"/> High blood pressure <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/>		
City: _____ State: _____			Chemical dependency <input type="checkbox"/> <input type="checkbox"/> Jaw pain <input type="checkbox"/> <input type="checkbox"/> Surgical implant <input type="checkbox"/> <input type="checkbox"/>		
How do you feel about your teeth?			Chemotherapy <input type="checkbox"/> <input type="checkbox"/> Kidney disease <input type="checkbox"/> <input type="checkbox"/> Swelling of feet/ankles <input type="checkbox"/> <input type="checkbox"/>		
MEDICAL UPDATE			Circulatory problems <input type="checkbox"/> <input type="checkbox"/> Liver disease <input type="checkbox"/> <input type="checkbox"/> Thyroid disease <input type="checkbox"/> <input type="checkbox"/>		
DATE	PATIENT SIGNATURE	DOCTOR SIGNATURE	Cortisone treatments <input type="checkbox"/> <input type="checkbox"/> Malnutrition <input type="checkbox"/> <input type="checkbox"/> Tobacco habit <input type="checkbox"/> <input type="checkbox"/>		
_____	_____	_____	Cough <input type="checkbox"/> <input type="checkbox"/> Material allergies <input type="checkbox"/> <input type="checkbox"/> Tonsillitis <input type="checkbox"/> <input type="checkbox"/>		
_____	_____	_____	Cough up blood <input type="checkbox"/> <input type="checkbox"/> (latex, wool, metal, chemicals) <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/>		
_____	_____	_____	Diabetes <input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> Ulcer/Colitis <input type="checkbox"/> <input type="checkbox"/>		
_____	_____	_____	Epilepsy <input type="checkbox"/> <input type="checkbox"/> Nervous problems <input type="checkbox"/> <input type="checkbox"/> Venereal disease <input type="checkbox"/> <input type="checkbox"/>		
			Family Physician: _____ Phone _____ Email _____		

Patient Signature: _____

Date: _____

Dentist Signature: _____

