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PATIENT REGISTRATION AND HEALTH HISTORY

Date ____________________ M_____ F _____
Patient's Name ____________________
Address ____________________
PLEASE CIRCLE NUMBER BEST TO REACH YOU! Home Phone ____________________
Cell phone ____________________ E-Mail ____________________
If patient is a minor, give parent's or guardian's name ____________________
Whom may we thank for referring you to our office? ____________________

RESPONSIBLE PARTY INFORMATION

Name ____________________ Marital Status __________
Residence ____________________ How Long? __________
Mailing Address ____________________ Home Phone __________
Social Security #____________________ Birthdate __________ Relationship to Pt. __________
Employer ____________________ Occupation __________ No. years employed __________
Work Phone ____________________ Cell Phone __________ E-Mail __________

Spouse's Name ____________________ Relationship to Pt. __________
Employer ____________________ Occupation __________ No. years employed __________
Social Security #____________________ Birthdate __________ Work Phone __________

INSURANCE INFORMATION

Insured's Name ____________________ Insured's Soc. Sec. #__________
Insurance Co. ____________________ Group #__________ Local # __________
Insurance Co. Address ____________________
Do you have dual coverage? _____ Yes _____ No if yes:
Insured's Name ____________________ Insured's Soc. Sec. #__________
Insurance Co. ____________________ Group #__________ Local # __________
Insurance Co. Address ____________________
Insured's Employer ____________________

EMERGENCY INFORMATION

Name of nearest relative not living with you ____________________
Complete Address ____________________
Phone ____________________ __________ Cell ____________________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) ____________________

HEALTH HISTORY

CIRCLE

1. Are you having pain or discomfort at this time? .... Yes No
2. Do you feel very nervous about having dental treatment? .... Yes No
3. Have you ever had a bad experience in the dental office? .... Yes No
4. How would your smile rate on a scale of 1-10? ____________
5. Do you clench or grind your jaw while sleeping or during the day? .... Yes No
6. When was your last dental visit? ____________
7. Have you been a patient in the hospital during the past two years? .... Yes No
8. Have you been under the care of a medical doctor during the past two years? .... Yes No

   Physician's Name ______________________________

   Address ______________________________ Phone# ____________________
9. Have you taken any medicine or durgs during the past two years? .... Yes No
10. Are you now taking any medicine, drugs or pills? .... Yes No
11. Please list medications ______________________________

____
12. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? .... Yes No

   ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Other

   If yes, please list: ______________________________
13. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Disease or Attack	Yes	No	Emphysema	Yes	No	Liver Disease	Yes	No
Angina	Yes	No	Tuberculosis (TB)	Yes	No	Yellow Jaundice	Yes	No
High Blood Pressure	Yes	No	Asthma	Yes	No	Blood Transfusion	Yes	No
Heart Murmur	Yes	No	Sinus Trouble	Yes	No	Drug Addiction	Yes	No
Rheumatic Fever	Yes	No	Allergies or Hives	Yes	No	Hemophilia	Yes	No
Congenital Heart Lesions	Yes	No	Diabetes	Yes	No	Venereal Disease		
Artificial Heart Valve	Yes	No	Thyroid Disease	Yes	No	(Syphilis, Gonorrhea)	Yes	No
Heart Pacemaker	Yes	No	X-ray or Cobalt Treatment	Yes	No	Cold Sores	Yes	No
Heart Surgery	Yes	No	Chemotherapy (Cancer, Leukemia)	Yes	No	Fever Blisters	Yes	No
Artifical Joints (Hip, Knee)	Yes	No	Arthritis	Yes	No	Epilepsy or Seizures	Yes	No
Anemia	Yes	No	Cortisone Medicine	Yes	No	Fainting or Dizzy Spells	Yes	No
Stroke	Yes	No	Glaucoma	Yes	No	Nervousness	Yes	No
Kidney Trouble	Yes	No	Pain in Jaw Joints	Yes	No	Psychiatric Treatment	Yes	No
Ulcers	Yes	No	A.I.D.S.	Yes	No	Sickel Cell Disease	Yes	No
Cosmetic Surgery	Yes	No	Hepatitis	Yes	No	Bruise Easily	Yes	No

14. When you walk stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? .... Yes No
15. Has your medical doctor ever said you have a cancer or tumor? .... Yes No
16. Do you have any disease, condition, or problem not listed? .... Yes No
17. Are you aware of any swelling or lump in your mouth? .... Yes No
18. Are you subject to prolonged bleeding? .... Yes No

   FOR WOMEN ONLY:

   Are you pregnant? Yes ☐ ☐ No If yes, what month? ________ Are you taking birth control pills? Yes ☐ ☐ No

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I understand the above information is necessary to provide me with dental care in a safe and efficent manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any diagnostic aids appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform any and all forms of treatment, medication and therapy that may indicated in connection with (Name of Patient) ______________________ and further authorize and consent choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. Balances not paid within 60 days will incur 1 1/2% per month (18% annual) interest charge. I further understand that in the event of default (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Signature ______________________________ Date ____________