Registration and Health History Form

WE HAVE THE INTEREST AND DESIRE TO LISTEN, REALLY LISTEN, TO WHAT YOU ARE SAYING. PLEASE DON'T HESITATE TO ASK ABOUT ANYTHING YOU DON'T UNDERSTAND. YOU ARE DEALING WITH MEMBERS OF A TEAM WHOSE PRIMARY JOB IS TO SERVE YOU. WE PROMISE THAT YOU WILL NEVER LEAVE FEELING THAT NO ONE CARES.

In order to begin treatment the following information is necessary. Please complete fully and print legibly. All information will be held in strict confidence.

Name_____ Home Ph:_____ Cell Ph:_____ Spouse's Name:_____
Last First Middle

If patient is a minor, please give the name of a parent or legal guardian_____
Last First Middle

Residence Address _____ City_____ State _____ Zip Code _____
Street

Mailing Address (if different than residence)_____ City_____ State_____ Zip Code_____
Street

Date of Birth_____ SS#_____ Sex: ☐ M ☐ F Email_____

Drivers License_____ Occupation_____ Employer_____

Employer Address_____ City_____ State_____ Zip Code_____
Street

Emergency Contact_____ Relationship_____ Phone _____

If you are completing this form for another person, what is your relationship to that person? _____
Name Relationship

How may we contact you? Phone ____ Mail ____ Email ____ Text Message ____ All ____

INSURANCE

Policy Holder: _____ Relationship to Patient: _____ Insured DOB: _____

SS# of Insured: _____ Insured Employer: _____ Insurance Company_____

Secondary Insurance: ☐ Yes ☐ No If Yes: Policy Holder:_____ Relationship to Patient: _____

Insured DOB: _____ SS# of Insured:_____ Insured Employer:_____

DENTAL INFORMATION

For the following questions, please (X) whichever applies. This information is vital to allow us to provide appropriate care for you.

Yes	No		Yes	No	
☐	☐	Do your gums occasionally bleed when you brush?	☐	☐	Have you ever had orthodontic (braces) treatment?
☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	Do you wear removable dental appliances?
☐	☐	Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain _____			

_____

How would you describe your current dental problem? _____

Former dentist_____ Reason for leaving_____

Date of your last dental exam_____ Date of last dental x-rays _____ What was done at that time? _____

Are you nervous about receiving dental care? ☐ Yes ☐ No Would you like to be sedated for treatments? ☐ Yes ☐ No

Are you a participant in any sport? ☐ Yes ☐ No Do you wear a mouth guard? ☐ Yes ☐ No

How do you feel about the appearance of your teeth? _____

MEDICAL INFORMATION

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition but they are all associated with proper oral care.

Yes	No	
☐	☐	Are you in good health?
☐	☐	Has there been any change in your general health within the past year?
☐	☐	Are you now under the care of a physician? If so, what is/are the condition(s) being treated? _____
		Date of last physical examination _____ Physician _____ NAME PHONE
☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? _____

_____

Yes No

☐ ☐ Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what are you taking and what is the dosage?
Prescribed _____
Over the counter _____
Natural or herbal preparations _____

☐ ☐ Are you taking, or have you taken, any diet drugs such Pondimin (fendluramine), Redux (dexphenfluramine) or phen-fen (phentermine)?

☐ ☐ Have you taken any of the following prescription medications? Circle one. ZOMETA AREDIA ACTONEL BONIVA FOSAMAX

☐ ☐ Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? _____ In the past month? _____

☐ ☐ Are you alcohol and/or drug dependent? If so, have you received treatment? ☐ Yes ☐ No

☐ ☐ Do you use drugs or other substances for recreational purposes? If yes, please list _____
Frequency of use (daily, weekly, etc.) _____ Number of years of recreational drug use _____

☐ ☐ Do you use tobacco (smoking, snuff, chew)? If yes, how much? _____

☐ ☐ Do you wear contact lenses?

ALLERGIES: ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO: (PLEASE FILL OUT EACH COLUMN)

Yes	No		Yes	No		Yes	No	
☐	☐	Local anesthetics	☐	☐	Sulfa drugs	☐	☐	Hay fever/seasonal
☐	☐	Aspirin	☐	☐	Codeine or other narcotics	☐	☐	Animals
☐	☐	Penicillin or other antibiotics	☐	☐	Latex	☐	☐	Food (Specify) _____
☐	☐	Barbiturates, sedatives, or sleeping pills	☐	☐	Iodine	☐	☐	Other (specify) _____

To yes responses, specify type of reaction _____

Yes No **WOMEN ONLY**

☐ ☐ Nursing?

☐ ☐ Are you pregnant? If yes, how many months? _____

☐ ☐ Taking birth control pills?

Do you now or have you ever had any of the following? Please check YES or NO to **ALL**

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal bleeding	☐	☐	Disease, drug, or radiation induced immunosurpression	☐	☐	Night sweats
☐	☐	AIDS or HIV infections				☐	☐	Osteoporosis
☐	☐	Angina. If yes, date: _____	☐	☐	Dry mouth	☐	☐	Persistent swollen glands/neck
☐	☐	Anemia	☐	☐	Eating disorder. If yes, specify: _____	☐	☐	Recurrent infections
☐	☐	Arteriosclerosis			_____	☐	☐	Respiratory problems
☐	☐	Arthritis	☐	☐	Epilepsy	☐	☐	Seizures
☐	☐	Asthma	☐	☐	Excessive urination	☐	☐	Severe headaches / migraines
☐	☐	Blood transfusion	☐	☐	Fainting spells or seizures	☐	☐	Severe or rapid weight loss
		If yes, date _____	☐	☐	G.I. reflux	☐	☐	Sexually transmitted disease
☐	☐	Cancer/chemotherapy/radiation	☐	☐	Glaucoma	☐	☐	Sinus trouble
		treatment. If yes, date: _____	☐	☐	Heart attack. If yes, date: _____	☐	☐	Sleep disorder
☐	☐	Cardiovascular disease	☐	☐	Hemophilia	☐	☐	Sores or ulcers in the mouth
☐	☐	**Artificial heart valves**	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	Stroke. If yes, date: _____
☐	☐	**Pacemaker**	☐	☐	High blood pressure	☐	☐	Systemic lupus erythematosus
☐	☐	**Damaged heart valves**	☐	☐	Implants	☐	☐	Thyroid problems
☐	☐	**Heart murmur**	☐	☐	Joint replacement. If yes, date: _____	☐	☐	TMJ
☐	☐	**Inborn heart defects**			Where: _____	☐	☐	Tuberculosis
☐	☐	**Mitral valve prolapse**	☐	☐	Kidney problems	☐	☐	Ulcers
☐	☐	**Rheumatic heart disease**	☐	☐	Low blood pressure	☐	☐	Do you have any disease, condition or
☐	☐	Chronic pain	☐	☐	Mental health disorders. If yes, specify:			problem not listed above that you think
☐	☐	Chest pain upon exertion			_____			I should know about? Please explain:
☐	☐	Diabetes, If yes, specify below:			_____			_____
		_____	☐	☐	Neurological disorders			_____
					If yes, specify" _____			_____

☐ ☐ Has a physician or previous dentist recommended that you take antibiotics prior to you dental treatment? If so, what antibiotic and dose? _____

Who may we thank for referring you to our office? _____

I certify that I have read and understand the above. To the best of my knowledge, all of the preceding answers are true and correct. I understand that it is my responsibility to advise this office of any changes in the information contained on this form. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable before or at the time of service unless other arrangements have been made. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. I hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnoses of any dental needs. I hereby authorize my dentist to release any and all medical or dental information to my insurance carrier for purpose of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____ _____ _____
Assistant Signature Date Dentist Signature Date