DENTAL REGISTRATION AND HEALTH HISTORY

DATE_____

Patient's Name_____What can we call you?_____

Mailing Address_____City_____State_____Zip_____

Sex: M F Age: _____ Birth date: _____ Status: Single Married Widow Separated

SS#_____ E-Mail address:_____

Home Phone Number:_____Work Phone Number:_____Cell Phone Number_____

Occupation:_____Employer: _____

How did you hear about our office? _____

1.Have you or any of your family members been seen by us before? **Yes** **No**

If yes,family member(s)?_____

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 at a dental office? **Yes** **No**

8. Have you been a patient in a hospital in the last two years? **Yes** **No**

9. Have you been under the care of a medical doctor in the past two years? **Yes** **No**

10. Have you taken any medications or drugs in the past two years? **Yes** **No**

11. Are you taking vitamins, herbal supplements, or "cures"? **Yes** **No**

12. Have you ever had any excessive bleeding requiring special treatment? **Yes** **No**

13. Are you currently taking Osteoporosis medication? **Yes** **No**

14. Have you had Botox or Dermal filler treatments in the last year ? **Yes** **No**

Allergies (please circle)

Aspirin Local Anesthetic
Barbiturates Penicillin
Codeine Sulfa
Iodine Metals
Latex Other_____

Medications

Please list all medications you are currently taking:

_____
_____
_____

Pharmacy:_____

Please check to indicate if you have had any of the following:

___Chest Pain
___Heart Failure
___Heart Disease or attack
___Angina Pectoris
___Heart Problems
___Liver Disease
___Heart Surgery
___High Blood Pressure
___Shortness of Breath
___Ulcers
___Mental Retardation
___Emphysema
___Fainting or dizzy spells
___Eating Disorder
___Epilepsy or Seizures
___Persistent Cough
___Hives or skin rash
___Alcoholism
___Herpes
___Glaucoma
___Steroid Treatment*
___Arthritis
___Any type of Implant*
___Dentures or Partials

___Heart Murmur*
___Rheumatic Fever*
___Psychiatric Treatment
___Sickle Cell Disease
___Diabetes
___Artificial Joints*
___Thyroid Disease
___Anemia
___Blood Transfusion
___Any type of transplant*
___Mitral Valve Prolapse *

___Tuberculosis (TB)
___Asthma
___Congenital Heart Problems*
___Hepatitis A (Infectious)
___Hepatitis B (Serum)
___Hepatitis C or other
___Heart Pacemaker
___Stroke
___Drug addiction
___Cold Sore
___Cancer (Type:_____)

___Birth Defects
___HIV positive, ARC, AIDS
___Sinus Trouble
___Use of Tobacco Products
___Bruise easily
___ Jaundice
___Radiation Therapy
___Kidney Trouble
___Hemophilia
___Chemotherapy

*Antibiotic pre-medication may be required prior to your visit

Have you ever experienced any of the following
Problems with your jaw:
Clicking ___
Pain in or around your ears ___
Difficulty opening or closing ___
Difficulty Chewing ___
Do you have a history of trauma to your jaw? ___
Have you ever been diagnosed with TMJ/TMD? ___

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

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

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 record 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 have had the opportunity to read and understand the HIPAA agreement. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I, the undersigned, do herby give my consent for any dental care for myself and/or my child that the examining dentist feels is necessary, including x-rays, fluoride treatments, fillings and extractions. I also give my consent for the use of local anesthetics, nitrous oxide-oxygen mixture and/or other drugs deemed necessary by the dentist. I also authorize the release of dental information necessary to process a claim to Medicare, or any insurance company.

Signature X_____Date_____

Witness_____