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REGISTRATION AND HEALTH HISTORY

DATE ______________

Name ______________ Birth Date ______________ Age ______
Address ______________ Phone ______________
City ______________ State ______ Zip ______
(Optional) Single ______ Married ______ Divorced ______ Widowed ______
Employed by ______________
Occupation ______________
Business Address ______________ Phone ______________
Spouse's Name ______________ Employed by ______________
Business Address ______________ Phone ______________
Closest Relative ______________ Phone ______________
Whom may we thank for referring you? ______________
Purpose of this appointment ______________
Who will be financially responsible for this account? ______________
Dental Insurance: Yes ____ No ____ Name of Company ______________
I.D.# of person insured ______________ Policy or Group# ______________
Additional insurance information ______________

It is important that we know about your dental and medical history. Many things have a direct bearing on your dental health. We will review the questionnaire and discuss it with you in detail. Information is strictly confidential.

MEDICAL HEALTH INFORMATION

Are you in good health? ______ Name of physician ______________ Phone ______________
Date of last medical exam ______________ Are you receiving medical care now? ______________
If yes, please explain ______________
Have you been hospitalized in the last five years? ______ For? ______________
Are you currently taking medication? ______ If yes, please list ______________

Do you have or have you had any of the following? Please circle yes or no.

Heart Murmur	YES	NO
Any heart condition	YES	NO
Rheumatic Fever	YES	NO
Joint Replacement	YES	NO
Pacemaker	YES	NO
High blood pressure	YES	NO
Low blood pressure	YES	NO
Shortness of breath	YES	NO
Swollen ankles	YES	NO
Asthma	YES	NO
Sinus problems	YES	NO
Diabetes	YES	NO
Circulatory problems	YES	NO
Arthritis	YES	NO
Hepatitis	YES	NO
Epilespsy or convulsions	YES	NO
Tuberculosis	YES	NO
Endocrine gland disturbance	YES	NO
Syphilis or Gonorrhea	YES	NO
Herpes	YES	NO
A.I.D.S., HIV infection	YES	NO
Anemia or blood disorder	YES	NO
Blood transfusions	YES	NO
Allergies to Anesthetics	YES	NO
Allergies to ______________	YES	NO
Allergies to medication ______________	YES	NO
Forms of cancer	YES	NO
Radiation therapy	YES	NO
Chemotherapy	YES	NO
Nervousness	YES	NO
Emotional disorder	YES	NO
Smoke tobacco	YES	NO
Hearing aid	YES	NO
Contact lenses	YES	NO
Recent weight change	YES	NO
Take aspirin daily	YES	NO

If you have any disease, condition, or problem not listed above, please explain ______________

Women: Are you pregnant at this time? ______

DENTAL HEALTH INFORMATION

Please circle yes or no

YES NO Any dental discomfort? Please explain ____________________
YES NO Teeth sensitive to cold?
YES NO To hot?
YES NO To sweets?
YES NO To pressure?
YES NO Any teeth removed? Reason ____________________
YES NO Complications after removal? ____________________
YES NO Teeth replaced?
YES NO Fixed bridge?
YES NO Removable partial denture?
YES NO Complete denture?
YES NO Replacements satisfactory? If no, why? ____________________
YES NO Surgery for tumors or cysts?
YES NO Red swellings or purple areas in your mouth?
YES NO Periodontal therapy (gum treatment)? When? ____________________
YES NO Endodontic therapy (root canal treatment)? When? ____________________
YES NO Do you grind or clench your teeth?
YES NO Have pain in or near your ears?
YES NO Any difficulty opening or closing your mouth?
YES NO Jaw muscle pain, neck area pain, or frequent headaches?
YES NO Any difficulty chewing?
YES NO Do your teeth meet comfortably?

Do you like the way your teeth look and feel? Yes ________ If not, please explain ____________________
____

How often do you visit the dentist? ____________________ When was your last appointment? ____________
Any problems associated with any previous treatment including reactions to local anesthetics? ____________
How often do you brush your teeth? ____________________
Do your gums bleed? ________ Have you been shown techniques for proper plaque removal and general oral health (brushing, flossing and other aids)? ________
Type of brush used: Hard? ________ Medium? ________ Soft? ________ How long do you use a toothbrush before replacing it? ________ How often do you floss? ________
Do you use any other mouth cleansing devices? ____________________ Do you experience unpleasant taste or mouth odor? ________ How many minutes a day do you spend practicing oral hygiene? ____________
Why did you select our office? ____________________
How may we best serve your needs? ____________________

I will pay for services when rendered unless other arrangements have been made in advance.

To avoid misunderstanding regarding dental insurance, we wish our patients to know that all services rendered are the direct financial responsibility of the patient. We will prepare insurance forms or reports to help you obtain your benefits from insurance companies.

Signature of Patient ____________________

Signature of Dentist ____________________