

PATIENT REGISTRATION AND MEDICAL/DENTAL HISTORY

Medical Alert

So that we may provide you with the best possible care, please complete both sides of this medical/dental history form.
(PLEASE PRINT)

Pharmacy Name _____ Phone _____

Date _____

Home Phone _____ Work Phone _____ Cell/Pager _____ Email _____

Patient Name _____

Address _____

City _____ State _____ Zip _____ Social Security # _____ Driver's Lic.# _____

Sex: Male _____ Female _____ Age _____ Birthday ____/____/____ Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Employed By _____

Occupation _____

Business Address _____

City _____ State _____ Zip _____ Tel. _____

Spouse Name _____ Birthday ____/____/____

Employed By _____

Business Address _____

City _____ State _____ Zip _____ Tel. _____

Social Security # _____

Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

Hm# () _____ DL# _____

Employer: _____

Wk# () _____ Ext. _____ SS# _____

Dental Insurance Primary Carrier

Insured's Name _____ Social Security # _____

Insurance Company _____ Telephone _____

Address _____

City _____ State _____ Zip _____

Group Number _____ ID Number _____ Birthdate _____

Insured's Employer _____

Dental Insurance Secondary Carrier

Insured's Name _____ Social Security # _____

Insurance Company _____ Telephone _____

Address _____

City _____ State _____ Zip _____

Group Number _____ ID Number _____ Birthdate _____

Insured's Employer _____

In case of emergency, who should be notified? _____ Tel. _____

Whom may we thank for referring you? _____

Medical History

Physician's Name _____ Date of Last Physical _____

Address _____ Tel. _____

Please check the box of any condition you may have had.

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> A.I.D.S./ HIV Positive or Other | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> General Allergies* (List Below) | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Allergy to Colored Dyes | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Allergy to Latex | <input type="checkbox"/> Cancer, Leukemia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Chemotherapy/Radiation Therapy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Premedicate | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Aspirin Taken Daily | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Respiratory Problem | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | | <input type="checkbox"/> Other* (List below) |

*General Allergies:

*Other:

Patient Name

DENTAL HISTORY

What is the reason for your visit today?

Is there anything about having dental treatment that you would like us to know? Yes No

If yes, please describe

Date of Last: Dental Visit Dental Cleaning Full Mouth X-ray Bitewing X-rays

What treatment was done at your last dental visit?

Previous Dentist's Name Telephone

Address

City State Zip Code

How often do you have dental examinations? How often do you floss?

What other dental aids do you use? (Interplak, toothpick, etc.)

Do you have any dental problems now? Yes No If yes, please describe:

Circle "Yes" or "No" to each item.

Do you: Are any of your teeth sensitive to: Have you ever experienced:
Clench or grind your teeth while awake or asleep?
Bite your lips or cheeks regularly?
Hold foreign objects with your teeth?
Mouth breathe while awake or asleep?
Have tired jaws, especially in the morning?
Smoke/chew tobacco?
How much?
Have you ever had:
Orthodontic treatment?
Oral surgery?
Periodontal treatment?
Your teeth ground or the bite adjusted?
A bite plate or mouth guard?
A serious injury to the mouth or head?
If yes, please describe, including cause.
Are any of your teeth sensitive to:
Hot or cold
Sweet
Biting or chewing
Have you noticed any mouth odors or bad tastes?
Do you frequently get cold sores, blisters or any other oral lesions?
Do your gums bleed or hurt?
Have your parents experienced gum disease or tooth loss?
Have you noticed any loose teeth or a change in your bite?
Do you have difficulty in chewing on either side of the mouth?
Does food tend to become caught in between your teeth?
If yes, where?
Have you ever experienced:
Clicking or popping of the jaw?
Pain? (joint, ear, side of face)
Difficulty in opening or closing the mouth?
Headaches, neckaches or shoulder aches?
Sore muscles (necks, shoulders)?
Are you happy with your smile?
Are you pleased with the color of your teeth?
Would you like to keep all of your teeth all of your life?
Do you feel nervous about having dental treatment?
If yes, what is your biggest concern?
Have you ever had an upsetting dental experience?
If yes, please describe

Do you have any drug allergies or have you ever had an adverse reaction to any medication or substance? Yes No

If yes, list

Have you ever responded adversely to medical or dental treatment? Yes No

Have you ever been advised to be pre-medicated prior to any dental treatment? Yes No

Are you taking any medication at this time? Yes No If yes, what

Have you ever taken Phen-Fen? Or Redux? Yes No If so, have you seen a cardiologist for a consult since taking it? Yes No

Are you under the care of a physician? Yes No If yes, for what condition

If Patient is a child what is his/her weight?

Have you had a recent transfusion? Yes No

Is there anything else we should know about your medical history

Women — Are you: Pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

AUTHORIZATION AND RELEASE

Staff /Dr.'s Initials Date

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners.

I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Signature of Patient or Parent of Minor

Date