

# HEALTH HISTORY & REGISTRATION

Chart #: \_\_\_\_\_  
FOR OFFICE USE ONLY

## PATIENT INFORMATION

Patient's Name \_\_\_\_\_ Sex: M F Today's Date \_\_\_\_\_  
Last First MI

If Patient is a Minor, give Parent's or Guardian' Name \_\_\_\_\_ Reason for this visit \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Ext \_\_\_\_\_ (Cell) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

E-mail Address \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

NAME \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_  
Street City State Zip Code

How Long At This Address \_\_\_\_\_ Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Previous Address (if less than 3 yrs.) \_\_\_\_\_  
Street City State Zip Code

Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_

Driver's License# \_\_\_\_\_ Relation To Patient \_\_\_\_\_

## INSURANCE INFORMATION

### Primary

Insured's Name: \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other

### EMERGENCY INFORMATION RELATIVE NOT LIVING WITH YOU

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State \_\_\_\_\_  
Phone \_\_\_\_\_

### HOW DID YOU HEAR ABOUT US?

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

\_\_\_\_\_

## CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a through diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a finance charge will be added to any overdue balance.

Patient Signature (Parent of Child) \_\_\_\_\_ Date: \_\_\_\_\_ Dentist Signature \_\_\_\_\_

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

***It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.***

**DENTAL HISTORY**

How long since you have seen a dentist? \_\_\_\_\_  
 Last complete dental exam, Date: \_\_\_\_\_ Last full mouth x-rays, Date: \_\_\_\_\_

	YES	NO
Are you having any problems now? What? _____	<input type="checkbox"/>	<input type="checkbox"/>
Please rate your current dental health? _____	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good
	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Are you apprehensive about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to hot, cold, sweets, pressure? (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed, or feel tender or irritated?	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly use dental floss?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of grinding or clenching your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have headaches, earaches, or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>
Have you worn braces on your teeth? (orthodontics)	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear Dentures? (Partial or Full)	<input type="checkbox"/>	<input type="checkbox"/>
Are you unhappy with your dentures?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to know more about permanent replacements?	<input type="checkbox"/>	<input type="checkbox"/>
Are you unhappy with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have discolored teeth that bother you?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your smile to look better or different?	<input type="checkbox"/>	<input type="checkbox"/>
Name of Previous Dentist: _____		
Address: _____ Phone: _____		
How do you feel about your teeth? _____		
<b>Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment</b>		
# _____ FEAR of pain      # _____ COST of treatment      # _____ LACK of concern      # _____ MISSING work time		

**MEDICAL HISTORY**

Do you have any current health problems? YES NO  
 Are you under a physician's care now? YES NO For what? \_\_\_\_\_  
 What medications are you currently taking? \_\_\_\_\_  
 Are you pregnant? YES NO  
 Do you smoke? YES NO

- CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:**
- |  |                                |                                 |                   |
|--|--------------------------------|---------------------------------|-------------------|
| Heart Disease or Attack                      | Angina Pectoris                | High Blood Pressure             | Heart Murmur      |
| Rheumatic Fever                              | Congenital Heart Lesions       | Mitral Valve Prolapse           | Heart Surgery     |
| Artificial Heart Valve                       | Heart Pacemaker                | Artificial Joints (Hip, Knee)   | Anemia            |
| Stroke                                       | Kidney Trouble                 | Ulcers                          | Liver Disease     |
| A.I.D.S./A.R.C./HIV Pos.                     | Hepatitis A (infectious)       | Hepatitis B (serum)             | Drug Addiction    |
| Blood Transfusion                            | Hemophilia (Bleeding Problems) | Fever Blisters                  | Nervousness       |
| Epilepsy or Seizures                         | Psychiatric Treatment          | Chemotherapy (Cancer, Leukemia) | Glaucoma          |
| Venereal Disease (Syphilis, Gonorrhea, etc.) | Bruise Easily                  | Emphysema                       | Tuberculosis (TB) |
| Cosmetic Surgery                             | Asthma                         | Hay Fever                       | Sinus Trouble     |
| Allergies or Hives                           | Diabetes                       | Thyroid Disease                 | Arthritis         |
| Radiation Treatment                          | Cortisone Medicine             | Pain in Jaw Joints              | Alcoholism        |

**ARE YOU ALLERGIC TO OR HAVE REACTED ADVERSELY TO ANY OF THE FOLLOWING?**  
 Aspirin      Local Anesthetic      Erythromycin      Nitrous Oxide      Codeine      Penicillin      Latex

Are you aware of being allergic to any other medications or substances?  
 If yes, please list: \_\_\_\_\_

Is there any other Medical or Dental information that you feel I should know about? \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone No. \_\_\_\_\_

**HIPAA COMPLIANCE NOTICE**

Your signature and date below signifies that you have received the HIPAA Compliance Notice.  
 Patient Signature (Parent of Child) \_\_\_\_\_ Date: \_\_\_\_\_