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? _____	☐	☐
Please rate your current dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor		
Are you apprehensive about dental treatment?	☐	☐
Are your teeth sensitive to hot, cold, sweets, pressure? (circle)	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Do your gums bleed, or feel tender or irritated?	☐	☐
Do you regularly use dental floss?	☐	☐
Are you aware of grinding or clenching your teeth?	☐	☐
Do you have headaches, earaches, or neck pains?	☐	☐
Have you worn braces on your teeth? (orthodontics)	☐	☐
Do you wear Dentures? (Partial or Full)	☐	☐
Are you unhappy with your dentures?	☐	☐
Would you like to know more about permanent replacements?	☐	☐
Are you unhappy with the appearance of your teeth?	☐	☐
Do you have discolored teeth that bother you?	☐	☐
Would you like your smile to look better or different?	☐	☐

Name of Previous Dentist: _____
Address: _____ Phone: _____

How do you feel about your teeth? _____

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment

#____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: _____