HEALTH HISTORY & REGISTRATION

Patient's Name ______________________ Birthdate __________ Sex: M F Age ______ Today's Date __________

Home Address ______________________ City __________ State ______ Zip ______

Previous Address (if less than 3 years) ______________________ City __________ State ______ Zip ______

Please Circle One: Single, Married, Separated, Divorced Widowed Occupation __________ Home Phone Number __________

Your Employer __________ How Long Employed ______ Your Soc. Sec. # __________ Work Phone __________

Are you a full time student? ☐ Yes ☐ No If a patient is a minor we need: Mother's Birthdate __________ Father's Birthdate __________

Name of Spouse (Parent if minor) __________ Person Responsible for Account __________

Address ______________________ City __________ State ______ Zip ______

Spouse's (parent's) Employer __________ Spouse's Soc. Sec. # __________ Work Phone __________

Referred to us by ______________________

Reason for this visit ______________________

EMERGENCY INFORMATION __________

Name, Address & Telephone of a Relative Not Living with you. __________

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ______________________

Insurance Co. ______________________

Insured's Co. Address ______________________

Insured's Employer ______________________

Insured's Soc. Sec. # __________ Group # ______ Ins. Co. Phone # ______

If you have double dental insurance coverage complete this for the second coverage

Insured's Name ______________________

Insurance Co. ______________________

Insured's Co. Address ______________________

Insured's Employer ______________________

Insured's Soc. Sec. # __________ Group # ______ Ins. Co. Phone # ______

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. This information is important for us to provide safe and comfortable dental care for you. Please let us know if there is any question or health problem that you would rather discuss personally with the doctor.

1. Are you in good health? .... Yes No
2. Has there been any change in your general health within the past year? .... Yes No
3. My last physical exam was on ______________________
4. Are you now under the care of a physician? .... Yes No
   If so, what is the condition being treated? ______________________
5. The name and location of my physician is ______________________
6. Have you had any serious illness or operation? .... Yes No
   If so, what was the illness or operation? ______________________
7. Have you been hospitalized or had a serious illness within the past five (5) years? .... Yes No
   If so, what was the problem? ______________________
8. Do you have or have you had any of the following diseases or problems?
   a. History of Rheumatic or Scarlet Fever .... Yes No
   b. Damaged heart valves or artificial heart valves, including murmur Yes No
   c. Congenial heart lesions .... Yes No
   d. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) (circle which) .... Yes No
      1. Do you have chest pain upon exertion? .... Yes No
      2. Are you ever short of breath after mild exercise? .... Yes No
      3. Do your ankles swell? .... Yes No
      4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? .... Yes No
      5. Do you have a cardiac pacemaker .... Yes No
   e. Anemia (blood disorder) .... Yes No
   f. Sinus trouble .... Yes No
   g. Asthma .... Yes No
   h. Hay fever .... Yes No
   I. Hives or a skin rash .... Yes No
   j. Fainting spells or seizures .... Yes No
   k. Diabetes .... Yes No
      1. Do you have a blood relative with diabetes? .... Yes No
      2. Are you thirsty often? .... Yes No
      3. Does your mouth become frequently dry? .... Yes No
   l. Hepatitis, jaundice or liver disease .... Yes No
   m. Arthritis .... Yes No

Please complete reverse side ——→ Over Please

l. Inflammatory rheumatism (painful swollen joints) Yes No
m. Stomach ulcers Yes No
n. Kidney trouble Yes No
o. Tuberculosis Yes No
p. Do you have a persistent cough or cough up blood? Yes No
q. Low blood pressure Yes No
r. Venereal Disease Yes No
s. Epilepsy Yes No
t. Psychiatric problems Yes No
u. Cancer Yes No
v. AIDS or other immunosuppressive disorders Yes No
w. Other ______

9. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? Yes No
  a. Do you bruise easily? Yes No
  b. Have you ever required a blood transfusion? Yes No
  If so, explain the circumstances ______

10. Have you ever taken Phen Phen® or Redux® for weight control? Yes No
11. Have you had surgery, radiation, or drug treatment for a tumor, growth, or other condition of your head or neck? Yes No
12. Are you taking any drug or medicine? Yes No
  If so, what? ______

13. Are you taking any of the following:
  a. Antibiotics or sulfa drugs Yes No
  b. Anticoagulants (blood thinners) Yes No
  c. Medicine for high blood pressure Yes No
  d. Cortisone (steroids) Yes No
  e. Tranquilizers Yes No
  f. Antihistamines Yes No
  g. Aspirin Yes No
  h. Insulin, lolbutamide (orinase) or similar drug Yes No
  i. Digitalis or drugs for heart trouble Yes No
  j. Nitroglycerin Yes No
  k. Oral contraceptive or other hormonal therapy Yes No
  j. Other ______

14. Are you allergic or have you reacted adversely to:
  a. Local anesthetics Yes No
  b. Penicillin or other antibiotics Yes No
  c. Sulfa drugs Yes No
  d. Barbiturates, sedatives, or sleeping pills Yes No
  e. Aspirin or NSAIDS Yes No
  f. Latex Yes No
  g. Codeine or other narcotics Yes No
  h. Jewelry or any metals Yes No
  i. Other ______

15. Do you have any disease, condition, or problem not listed above that you think we should know about? Yes No
  If so, explain ______
16. Do you use tobacco? What kind ______ How Much ______ How long? ______ Yes No
17. Have you had any serious trouble associated with any previous dental treatment? Yes No
  If so, explain ______

18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? Yes No
19. Do you have or are you wearing contact lenses, hearing aids or other device or prostheses? (circle which) Yes No
20. Are you wearing any removable dental appliances? Yes No
21. Have you had any dental implants or augmentation procedures? Yes No
22. Women: Are you pregnant? Yes No
23. Women: Are you nursing? Yes No
24. Have you been through an educational dental preventive program? Yes No
25. Do your gums bleed, burn or itch at any time; or have you been told you have periodontal problems? Yes No
26. Have you ever had Nitrous Oxide gas during dental treatment? Yes No
  Result ______
27. Would you like your teeth to look better or different? Yes No
  If so, what ______
28. Are you apprehensive or nervous about dental treatment? Yes No
  What bothers you the most? ______
29. Have you had dental x-rays taken in the past few years? Yes No
  If so, where and what kind ______
30. Why did you select our office and what do you expect from us? ______

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

______
Signature of Patient

______
Signature of Dentist