

# Registration and Health History Form

WE HAVE THE INTEREST AND DESIRE TO LISTEN, REALLY LISTEN, TO WHAT YOU ARE SAYING. PLEASE DON'T HESITATE TO ASK ABOUT ANYTHING YOU DON'T UNDERSTAND. YOU ARE DEALING WITH MEMBERS OF A TEAM WHOSE PRIMARY JOB IS TO SERVE YOU. WE PROMISE THAT YOU WILL NEVER LEAVE FEELING THAT NO ONE CARES.

In order to begin treatment the following information is necessary. Please complete fully and print legibly. All information will be held in strict confidence.

Name \_\_\_\_\_ Home Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
Last First Middle

If patient is a minor, please give the name of a parent or legal guardian \_\_\_\_\_  
Last First Middle

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

Mailing Address (if different than residence) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Street

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Sex:  M  F Email \_\_\_\_\_

Drivers License \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

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

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

If you are completing this form for another person, what is your relationship to that person? \_\_\_\_\_  
Name Relationship

How may we contact you? Phone \_\_\_\_\_ Mail \_\_\_\_\_ Email \_\_\_\_\_ Text Message \_\_\_\_\_ All \_\_\_\_\_

## INSURANCE

Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

SS# of Insured: \_\_\_\_\_ Insured Employer: \_\_\_\_\_ Insurance Company \_\_\_\_\_

Secondary Insurance:  Yes  No If Yes: Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insured DOB: \_\_\_\_\_ SS# of Insured: \_\_\_\_\_ Insured Employer: \_\_\_\_\_

## DENTAL INFORMATION

For the following questions, please (X) whichever applies. This information is vital to allow us to provide appropriate care for you.

<p><b>Yes No</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Do your gums occasionally bleed when you brush?</p> <p><input type="checkbox"/> <input type="checkbox"/> Are your teeth sensitive to cold, hot, sweets or pressure?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you had any periodontal (gum) treatments?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain _____</p>	<p><b>Yes No</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Have you ever had orthodontic (braces) treatment?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have headaches, earaches or neck pains?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you wear removable dental appliances?</p>
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How would you describe your current dental problem? \_\_\_\_\_

Former dentist \_\_\_\_\_ Reason for leaving \_\_\_\_\_

Date of your last dental exam \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_ What was done at that time? \_\_\_\_\_

Are you nervous about receiving dental care?  Yes  No Would you like to be sedated for treatments?  Yes  No

Are you a participant in any sport?  Yes  No Do you wear a mouth guard?  Yes  No

How do you feel about the appearance of your teeth? \_\_\_\_\_

## MEDICAL INFORMATION

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition but they are all associated with proper oral care.

**Yes No**

Are you in good health?

Has there been any change in your general health within the past year?

Are you now under the care of a physician? If so, what is/are the condition(s) being treated? \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Physician \_\_\_\_\_  
NAME PHONE

Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? \_\_\_\_\_

- Yes No**
- Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what are you taking and what is the dosage?  
 Prescribed \_\_\_\_\_  
 Over the counter \_\_\_\_\_  
 Natural or herbal preparations \_\_\_\_\_
- Are you taking, or have you taken, any diet drugs such Pondimin (fendluramine), Redux (dexphenfluramine) or phen-fen (phentermine)?
- Have you taken any of the following prescription medications? Circle one. ZOMETA AREDIA ACTONEL BONIVA FOSAMAX
- Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? \_\_\_\_\_ In the past month? \_\_\_\_\_
- Are you alcohol and/or drug dependent? If so, have you received treatment?  Yes  No
- Do you use drugs or other substances for recreational purposes? If yes, please list \_\_\_\_\_  
 Frequency of use (daily, weekly, etc.) \_\_\_\_\_ Number of years of recreational drug use \_\_\_\_\_
- Do you use tobacco (smoking, snuff, chew)? If yes, how much? \_\_\_\_\_
- Do you wear contact lenses?

**ALLERGIES: ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO: (PLEASE FILL OUT EACH COLUMN)**

- | Yes                      | No                       |  | Yes                      | No                       |                            | Yes                      | No                       |                       |
|--------------------------|--------------------------|--|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Local anesthetics                          | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa drugs                | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever/seasonal    |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin                                    | <input type="checkbox"/> | <input type="checkbox"/> | Codeine or other narcotics | <input type="checkbox"/> | <input type="checkbox"/> | Animals               |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other antibiotics            | <input type="checkbox"/> | <input type="checkbox"/> | Latex                      | <input type="checkbox"/> | <input type="checkbox"/> | Food (Specify) _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates, sedatives, or sleeping pills | <input type="checkbox"/> | <input type="checkbox"/> | Iodine                     | <input type="checkbox"/> | <input type="checkbox"/> | Other (specify) _____ |
- To yes responses, specify type of reaction \_\_\_\_\_

**Yes No WOMEN ONLY**

- Nursing?
- Are you pregnant? If yes, how many months? \_\_\_\_\_
- Taking birth control pills?

Do you now or have you ever had any of the following? Please check YES or NO to ALL

- | Yes                      | No                       |   | Yes                      | No                       |  | Yes                      | No                       |  |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal bleeding   | <input type="checkbox"/> | <input type="checkbox"/> | Disease, drug, or radiation induced immunosuppression  | <input type="checkbox"/> | <input type="checkbox"/> | Night sweats   |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS or HIV infections  | <input type="checkbox"/> | <input type="checkbox"/> | Dry mouth  | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis   |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina. If yes, date: _____                                     | <input type="checkbox"/> | <input type="checkbox"/> | Eating disorder. If yes, specify: _____                | <input type="checkbox"/> | <input type="checkbox"/> | Persistent swollen glands/neck   |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia  | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy   | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent infections   |
| <input type="checkbox"/> | <input type="checkbox"/> | Arteriosclerosis  | <input type="checkbox"/> | <input type="checkbox"/> | Excessive urination                                    | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis   | <input type="checkbox"/> | <input type="checkbox"/> | Fainting spells or seizures                            | <input type="checkbox"/> | <input type="checkbox"/> | Seizures   |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma  | <input type="checkbox"/> | <input type="checkbox"/> | G.I. reflux  | <input type="checkbox"/> | <input type="checkbox"/> | Severe headaches / migraines   |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion<br>If yes, date _____                         | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma   | <input type="checkbox"/> | <input type="checkbox"/> | Severe or rapid weight loss  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/chemotherapy/radiation<br>treatment. If yes, date: _____ | <input type="checkbox"/> | <input type="checkbox"/> | Heart attack. If yes, date: _____                      | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease   |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular disease  | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia   | <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble  |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial heart valves   | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, jaundice or liver disease                   | <input type="checkbox"/> | <input type="checkbox"/> | Sleep disorder   |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker   | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                                    | <input type="checkbox"/> | <input type="checkbox"/> | Sores or ulcers in the mouth   |
| <input type="checkbox"/> | <input type="checkbox"/> | Damaged heart valves  | <input type="checkbox"/> | <input type="checkbox"/> | Implants   | <input type="checkbox"/> | <input type="checkbox"/> | Stroke. If yes, date: _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur  | <input type="checkbox"/> | <input type="checkbox"/> | Joint replacement. If yes, date: _____<br>Where: _____ | <input type="checkbox"/> | <input type="checkbox"/> | Systemic lupus erythematosus   |
| <input type="checkbox"/> | <input type="checkbox"/> | Inborn heart defects  | <input type="checkbox"/> | <input type="checkbox"/> | Kidney problems  | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral valve prolapse   | <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure                                     | <input type="checkbox"/> | <input type="checkbox"/> | TMJ  |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic heart disease   | <input type="checkbox"/> | <input type="checkbox"/> | Mental health disorders. If yes, specify: _____        | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis   |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic pain  | <input type="checkbox"/> | <input type="checkbox"/> | Neurological disorders<br>If yes, specify" _____       | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers   |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain upon exertion  |                          |                          |  |                          |                          | Do you have any disease, condition or<br>problem not listed above that you think<br>I should know about? Please explain:<br>_____<br>_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes, If yes, specify below:<br>_____                       |                          |                          |  |                          |                          |  |

- Has a physician or previous dentist recommended that you take antibiotics prior to you dental treatment? If so, what antibiotic and dose? \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

I certify that I have read and understand the above. To the best of my knowledge, all of the preceding answers are true and correct. I understand that it is my responsibility to advise this office of any changes in the information contained on this form. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable before or at the time of service unless other arrangements have been made. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. I hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnoses of any dental needs. I hereby authorize my dentist to release any and all medical or dental information to my insurance carrier for purpose of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

Signature of Patient/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Assistant Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_