HEALTH HISTORY AND PATIENT REGISTRATION FORM

ACCOUNT NUMBER

Date. _____

Name _____

Address: _____

City _____ State _____ Zip _____

Own ( ) Rent ( ) How Long _____ Previous Address if less than 3 yrs. _____

Home Phone: _____ Business Phone _____

Birthdate: _____ Cell Phone _____

E-mail _____

Please circle one: single, married, widowed, separated, divorced

Place of Employment: _____ Position/Title _____

Social Security # _____

IF MARRIED:

Spouse's Name _____ Birthdate _____ Social Security # _____

Place of Employment _____ Spouse Employment Phone _____

Closest Relative not living with you _____ Phone _____

REFERRED BY: Doctor (name) _____ Patient _____

Staff _____ Advertisement (location) _____ Sign Yellow Pages _____

DENTAL INSURANCE INFORMATION

Insured Name _____

Insurance Company _____

Insurance Co. Address _____

_____

Insured's Employer _____

Group or Policy # _____

Insurance Co. Phone _____

MEDICAL HISTORY

For the following questions, circle yes or no, whichever applies. Your answers are for our records only, and will be considered confidential.

These facts have a direct bearing on your dental health.

Sex ..... Height ..... Weight ..... Age ..... Race .....

	DATE ___/___/___		DATE ___/___/___	
1. Are you in good general Health?	Yes	No	Yes	No
2. Has there been any change in your general health within the year?	Yes	No	Yes	No
3. My last physical examination was on (approx. date) _____				
4. Are you under a physician's care?	Yes	No	Yes	No
If yes, for what condition? _____				
5 The name and address of your physician is _____				
_____				
6. Have you had any serious illness or operation?	Yes	No	Yes	No
If so, please list. _____				
7. Have you been hospitalized or had a serious illness within the past five years?	Yes	No	Yes	No
If yes, reason				

Medical History (cont.)

	DATE ___/___/___		DATE ___/___/___	
Cardiovascular system				
CV1. Do you have or have you ever had any of the following ..... Please circle one				
A. Heart trouble, heart attack, stroke, coronary insufficiency, damaged heart valves, congenital heart disease?	Yes	No	Yes	No
CV2. Rheumatic heart disease, Heart murmur?	Yes	No	Yes	No
CV3. Chest pain after exertion?	Yes	No	Yes	No
CV4. Shortness of breath after mild exercise?	Yes	No	Yes	No
CV5. Do your ankles swell?	Yes	No	Yes	No
CV6. Do you use extra pillows to sleep?	Yes	No	Yes	No
CV7. Do you have a cardiac pacemaker?	Yes	No	Yes	No
CV8. Do you have any blood pressure problems?	Yes	No	Yes	No
High ..... Low				
Central Nervous system				
CN1. Do you have or have you ever had				
A. Epilepsy?	Yes	No	Yes	No
B. Fainting Spells?	Yes	No	Yes	No
C. Seizures?	Yes	No	Yes	No
D. Emotional Disturbances?	Yes	No	Yes	No
CN2. Do you follow any treatment for a nervous disease?	Yes	No	Yes	No
Respiratory system				
RE1. Do you have a persistent cough or cold?	Yes	No	Yes	No
RE2. Do you have or have you ever had Tuberculosis ?	Yes	No	Yes	No
RE3. Is there any history of Tuberculosis in your family?	Yes	No	Yes	No
RE4. Do you have any sinusitis, sinus trouble?	Yes	No	Yes	No
RE5. Do you have Emphysema, Chronic Bronchitis, Asthma?	Yes	No	Yes	No
Digestive system				
GI1. Do you have any stomach ulcers?	Yes	No	Yes	No
GI2. Do you have or have you ever had	Yes	No	Yes	No
Hepatitis?	Yes	No	Yes	No
Jaundice?	Yes	No	Yes	No
Liver Disease	Yes	No	Yes	No
GI3. Have you ever vomited blood?	Yes	No	Yes	No
GI4. Do you have any diarrhea?	Yes	No	Yes	No
Endocrine system				
EN1. Do you have Diabetes?	Yes	No	Yes	No
EN2. Does anyone in your family have diabetes?	Yes	No	Yes	No
EN3. Do you urinate more than 6 times a day?	Yes	No	Yes	No
EN4. Are you thirsty very often or do you have a dry mouth?	Yes	No	Yes	No
EN5. Do you have Hypothyroidism or Hyperthyroidism?	Yes	No	Yes	No

Medical History (cont.)

	DATE ___/___/___		DATE ___/___/___	
Hematopoietic system				
HB1. Do you have Anemia, Sickle cell disease, Blood disorder?	Yes	No	Yes	No
HB2. Is there any family history of blood disorders?	Yes	No	Yes	No
HB3. Are you a hemophilic?	Yes	No	Yes	No
HB4. Have you had abnormal bleeding after any surgery, extraction, or trauma?	Yes	No	Yes	No
HB5. Have you ever had a blood transfusion?	Yes	No	Yes	No
Allergies				
AL1. Are you allergic to or have you acted adversely to				
A. Local Anesthetics?	Yes	No	Yes	No
B. Antibiotics, Penicillin, Sulfadrugs?	Yes	No	Yes	No
C. Barbiturates, sedatives, or sleeping pills?	Yes	No	Yes	No
D. Aspirin?	Yes	No	Yes	No
E. Iodine?	Yes	No	Yes	No
F. **Codeine or other narcotics?**	Yes	No	Yes	No
G. Other? _____	Yes	No	Yes	No
AL2. Do you have Asthma or Hay Fever?	Yes	No	Yes	No
AL3. Do you have or have you ever had Hives or Skin rash?	Yes	No	Yes	No
Genitourinary system				
UR1. Do you have or have you ever had				
A. Kidney Trouble?	Yes	No	Yes	No
B. Syphilis, Gonorrhea?	Yes	No	Yes	No
C. Immune System Compromising Diseases?	Yes	No	Yes	No
Bone-Joints				
BJ1. Do you have				
A. Arthritis?	Yes	No	Yes	No
B. Inflammatory Rheumatism?	Yes	No	Yes	No
C. Bone Infection?	Yes	No	Yes	No
D. Osteoporosis?	Yes	No	Yes	No
Neoplasms				
TR1. Do you have or have you ever had				
A. Tumor or malignancy?	Yes	No	Yes	No
B. Chemotherapy, or Radiation Therapy?	Yes	No	Yes	No
Do you have any disease, condition or problem not listed above that you think we should know about? _____	Yes	No	Yes	No
Are you regularly exposed to x-rays or any other ionizing radiation or toxic substances?	Yes	No	Yes	No
Do you have Glaucoma? If yes, wide or close angle	Yes	No	Yes	No
Are you wearing, or do you wear, contact lenses?	Yes	No	Yes	No
Do you drink alcohol? If yes, how much and how often	Yes	No	Yes	No
Do you smoke or use tobacco? If yes, how much and how often	Yes	No	Yes	No

Medical History (cont.)

	DATE __/__/__		DATE __/__/__	
Medications				
ME1. Are you taking any of the following medications? If yes, please list below				
A. Antibiotics, or sulfa drugs?	Yes	No	Yes	No
B. Anticoagulants? (blood thinners)	Yes	No	Yes	No
C. Medicine for high blood pressure?	Yes	No	Yes	No
D. Tranquilizers?	Yes	No	Yes	No
E. Iodine?	Yes	No	Yes	No
F. Codeine or other Narcotics?	Yes	No	Yes	No
G. Other? _____	Yes	No	Yes	No
Women				
1. Are you pregnant? Or Nursing? If yes, please circle which	Yes	No	Yes	No
2. Do you have any problems associated with your menstrual period?	Yes	No	Yes	No
3. Are you taking oral contraceptives or hormonal therapy?	Yes	No	Yes	No
Dental History				
1. What is your chief dental complaint? _____				
2. Are you experiencing any discomfort or pain at this time?	Yes	No	Yes	No
3. Are you satisfied with the appearance of your teeth?	Yes	No	Yes	No
4. Are you able to eat and chew foods satisfactorily?	Yes	No	Yes	No
5. Do you have headaches, earaches, or neck pain?	Yes	No	Yes	No
6. Do you frequently experience sinus problems?	Yes	No	Yes	No
7. Have you had any serious trouble associated with any previous dental treatment?	Yes	No	Yes	No
If yes, please explain _____				

Responsibility and Consent Statement

I hereby authorize and request the performance of dental services for myself or for

_____

I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment. These records may include study models, photographs, x-rays, and blood studies.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

Treatment plans involving extended credit circumstances are subject to a credit check. I also understand that the treatment estimate presented to me is only an estimate. Occassionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment, and its fee.

To the best of my knowledge the information provided in this form is accurate

Signature of Patient _____

Signature of Doctor _____

Date _____