

PATIENT REGISTRATION AND HEALTH HISTORY

MEDICAL ALERT: _____

WELCOME TO OUR OFFICE! IN AN EFFORT TO PROVIDE YOU WITH EXCEPTIONAL DENTAL CARE WE REQUIRE A COMPLETE MEDICAL AND DENTAL HISTORY. BE ASSURED THAT ANY AND ALL INFORMATION IS KEPT IN STRICT CONFIDENCE. PLEASE TAKE A FEW MOMENTS AND COMPLETE THIS QUESTIONNAIRE.

I. PERSONAL INFORMATION:

FULL NAME: SSN#:		BIRTHDATE:	
ADDRESS:		CITY	POSTAL CODE
HOME TELE. #:	WORK #:	E-MAIL:	
INSURANCE CARRIER:	GROUP#:	EMPLOYER:	
NAME OF SPOUSE/SIGNIFICANT OTHER:		BIRTHDATE:	SSN#:
SECONDARY CARRIER:		GROUP#:	EMPLOYER:

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

II. MEDICAL HISTORY: (CONFIDENTIAL)

PHYSICIAN NAME:	PHYSICIAN PHONE:
1. ARE YOU IN GOOD HEALTH?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. DO YOU SMOKE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. HAVE YOU EVER HAD A SERIOUS ILLNESS, OPERATION, OR HOSPITALIZATION?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN FOR ANY ONGOING TREATMENT? ...	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. MY LAST PHYSICAL EXAM WAS _____	
6. ARE YOU NOW TAKING ANY MEDICINE, DRUGS OR PILLS?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, PLEASE LIST: _____	
7. DO YOU HAVE ANY ALLERGIES? IF YES, TO WHAT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS? (PLEASE CIRCLE): ANY HEART DISEASE, ARTIFICIAL HEART VALVE, HIGH BLOOD PRESSURE ASTHMA, TUBERCULOSIS, ANY LUNG DISEASE, HIVES OR SKIN RASH, ANY KIDNEY TROUBLE, HEPATITIS, JAUNDICE, ANY LIVER DISEASE, ULCERS, ANY ARTHRITIS, RHEUMATIC FEVER, CANCER, AIDS, DRUG ADDICTION, HEMOPHILLIA, MENTAL OR NERVOUS DISORDER, EPILEPSY, ANOREXIA, BULIMIA.	
9. DO YOU OR HAS ANY MEMBER OF YOUR FAMILY HAD DIABETES?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
10. DO YOU HAVE ANY BLOOD DISORDERS OR DO YOU BLEED EXCESSIVELY?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
11. HAVE YOU EVER HAD INJURY, SURGERY, OR X-RAY THERAPY TO FACE OR JAWS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
12. DO YOU HAVE A TENDENCY TO FAINT?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
13. DO YOU HAVE FREQUENT SEVERE HEADACHES?	<input type="checkbox"/> YES <input type="checkbox"/> NO
14. ARE YOU ON A SPECIAL DIET?	<input type="checkbox"/> YES <input type="checkbox"/> NO
15. DO YOU HAVE A PROSTHETIC IMPLANT? (I.E. HIP JOINT)	<input type="checkbox"/> YES <input type="checkbox"/> NO
16. WOMEN ONLY - ARE YOU PREGNANT? (WHICH MONTH _____).....	<input type="checkbox"/> YES <input type="checkbox"/> NO
17. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE THAT YOU THINK THE DENTIST SHOULD KNOW ABOUT? IF YES, PLEASE EXPLAIN:.....	<input type="checkbox"/> YES <input type="checkbox"/> NO

DATE: _____ PATIENT/GUARDIAN SIGNATURE: _____

PROVIDER'S SIGNATURE: _____

III. DENTAL HISTORY

- A. WHAT CONCERNS YOU MOST ABOUT YOUR DENTAL HEALTH? _____
- B. DO YOU SEE A DENTIST ON A ROUTINE BASIS? YES NO
- I. DATE OF LAST DENTAL VISIT _____
- II. DATE OF LAST DENTAL CLEANING _____
- III. DATE OF LAST FULL MOUTH X-RAYS _____
- C. ARE YOU HAVING PAIN AT THIS TIME?..... YES NO
- D. HAVE YOU EVER HAD:
- I. ORTHODONTIC TREATMENT (BRACES)?..... YES NO
- II. ORAL SURGERY?..... YES NO
- III. PERIODONTAL TREATMENT (GUM SURGERY)?..... YES NO
- IV. WORN A BITE GUARD OR OTHER APPLIANCE? YES NO
- E. HAVE YOU EVER NOTICED ANY LOOSENING OF YOUR TEETH?..... YES NO
- F. DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?..... YES NO
- G. DO YOU SUFFER FROM PAIN AND/OR SWELLING OF YOUR GUMS?..... YES NO
- H. DO YOUR GUMS OFTEN BLEED WHEN YOU BRUSH YOUR TEETH?..... YES NO
- I. PROBLEMS OF THE JAW. HAVE YOU EXPERIENCED:
- I. CLICKING OF THE JAW?..... YES NO
- II. PAIN (JOINT, EAR, SIDE OF FACE)?..... YES NO
- III. DIFFICULTY OPENING OR CLOSING?..... YES NO
- IV. DIFFICULTY IN CHEWING?..... YES NO
- J. HABITS. DO YOU:
- I. CLENCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? YES NO
- II. BITE YOUR LIPS OR CHEEKS REGULARLY? YES NO
- III. HOLD FOREIGN OBJECTS WITH YOUR TEETH (PENCILS, PIPE, PENS, NAILS)? YES NO
- IV. MOUTH BREATHE WHILE AWAKE OR ASLEEP?..... YES NO
- K. DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT?..... YES NO
- L. HAVE YOU EVER HAD AN UPSETTING EXPERIENCE IN A DENTAL OFFICE?..... YES NO
- M. IS IT IMPORTANT TO KEEP YOUR TEETH?..... YES NO
- N. ARE YOU DISSATISFIED WITH THE APPEARANCE OF YOUR SMILE?..... YES NO
- IF YOU COULD, WHAT FEATURES OF YOUR SMILE WOULD LIKE TO CHANGE?
- _____
- O. IS THERE ANYTHING ELSE ABOUT HAVING DENTAL TREATMENT THAT BOTHERS YOU? YES NO
- PLEASE EXPLAIN: _____

P. INSURANCE COMPANIES NOW ONLY ALLOW FOR "FUNCTIONALLY ACCEPTABLE WORK", WHEREAS, IN THE PAST THEIR COVERAGE WAS FOR "QUALITY WORK". IT IS OUR GOAL TO PROVIDE OUR PATIENTS WITH THE HIGHEST QUALITY WORK WITHIN THEIR FINANCIAL CAPABILITIES AND DESIRES.

WHAT IS IMPORTANT TO YOU? (CHECK ONE)

- THE HIGHEST QUALITY DENTISTRY AVAILABLE
- THE MOST ECONOMICAL TREATMENT PLAN
- DENTISTRY LIMITED TO INSURANCE COVERAGE
- A COMBINATION OF THE ABOVE, PLEASE EXPLAIN: _____

CONSENT:

THE UNDERSIGNED HEREBY AUTHORIZES THE DENTIST TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DENTIST TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S DENTAL NEEDS. I ALSO AUTHORIZE THE DENTIST TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION AND THERAPY, THAT MAY BE INDICATED IN CONNECTION WITH _____'S TREATMENT AFTER DISCUSSION AND CONSULTATION BETWEEN THE NAMED PATIENT (OR GUARDIAN OF) AND THE DENTIST INCLUDING ALTERNATIVE OPTIONS OR THE CONSEQUENCES OF NO TREATMENT. I ALSO UNDERSTAND THE USE OF ANESTHETIC AGENTS EMBODIES A CERTAIN RISK.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE: _____

