Patient Registration – Medical/Dental History

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Patient Information

PATIENT'S NAME: Last _____ First _____ Middle Initial ____
Preferred Name/Nickname _____ Today's Date _____ mm/dd/yyyy
SEX: M☐ F☐ Birthdate _____ mm/dd/yyyy
ADDRESS Street_____ Apt#_____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email _____
If Minor, Parent's or Guardian's Name(s) _____
Reason for Today's Visit _____
Who may we thank for referring you to our practice? _____
Do you have Insurance: Yes☐ No☐
Are you the Policy Holder? Yes☐ No☐
If not please provide the responsible party information.

Responsible Party Information (if not same as above)

NAME: Last _____ First _____ Middle Initial ____
Relationship to Patient _____ Insurance ID #: _____
SEX: M☐F☐ Marital Status _____ Birthdate _____ mm/dd/yyyy
ADDRESS Street_____ Apt#_____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone_____ Work Phone _____
Email: _____
Driver's License # _____ State Issued _____
Employer _____ Occupation _____ Years Employed _____

Insurance information

Policy Holder's Name _____ Member ID _____
Policy Holder's Date of Birth _____mm/dd/yyyy
Employer's Name_____
Address _____
Address 2 _____
City, State, Zip _____

Relationship to Policy Holder_____
Ins. Company _____
Address _____
Address2 _____
City, State, Zip _____

Emergency Contact Information

Name _____ Relationship _____
Address_____
Home Phone _____ Cell Phone _____
Work Phone _____ Email_____

It is very important that we know your Medical and Dental history. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to fill out this form.

DENTAL HISTORY *Please Circle "Yes" or "No" and describe where necessary.*

Do you have a specific dental problem? .....Yes ☐ No ☐
Describe _____
Do you have dental examinations on a routine basis? .....Yes ☐ No ☐
Approx. date of last visit _____
Date of last full mouth x-rays (14 films, or a Panoramic) .....Yes ☐ No ☐
Have you had any periodontal (gum) treatments? .....Yes ☐ No ☐
Describe_____
Do you floss your teeth on a routine basis? How often?_____ .....Yes ☐ No ☐
Do your gums ever bleed, feel tender, or irritated? .....Yes ☐ No ☐
Describe_____
Are your teeth sensitive to hot, cold, sweets, or chewing? .....Yes ☐ No ☐
Describe_____
Are you happy with your smile? Why or why not?_____ .....Yes ☐ No ☐
Do you ever hear clicking or popping, or feel discomfort in your jaw? .....Yes ☐ No ☐
Do you clench or grind your teeth?.....Yes ☐ No ☐
Describe_____
Are you apprehensive about dental treatment? If yes, why? .....Yes ☐ No ☐
Do you smoke or use tobacco products? Describe frequency_____ ...Yes ☐ No ☐
Name, address, phone of previous dentist_____
_____

MEDICAL HISTORY *Please Check "Yes" or "No" and describe where necessary.*

Are you currently under the care of a physician? .....Yes ☐ No ☐
Why?_____
Physician's Name _____ Phone _____
Have you ever had a major operation? .....Yes ☐ No ☐
Describe _____
Have you ever had a serious injury to your head or neck? .....Yes ☐ No ☐
Describe _____
Are you taking any medications, pills or drugs? .....Yes ☐ No ☐
Please list _____

Are you allergic to any medications or substances? Please check below ..... Yes ☐ No ☐
❑ Asprin ❑ Penicillin/Amoxicillin ❑ Erythromycin ❑ Codeine
❑ Nitrous Oxide ❑ Local Anesthetic ❑ Latex
❑ Other _____

Are you taking, or have you taken bisphosphonate drugs? Please check below .....Yes ☐ No ☐
❑ Fosamax ❑ Boniva ❑ Actonel ❑ Skelid ❑ Didronel
❑ IV Aredia ❑ IV Zometa

Women (Please check): ❑ Pregnant ❑ Trying to get pregnant
❑ Nursing ❑ Taking oral contraceptives

*Do you or have you ever had any of the following? Please check appropriate boxes. *If yes to any of these starred conditions, please call prior to your appointment as pre-medication may be necessary.*

	Y	N		Y	N		Y	N
Heart Disease/Surgery*			Shortness of Breath			Liver Disease		
Heart Murmur*			Frequent Cough			Kidney Problems		
Mitral Valve Prolapse*			Hay Fever			Renal Dialysis		
Rheumatic Fever*			Sinus Trouble			Thyroid Disease		
Artificial Heart Valve*			Asthma			Parathyroid Disease		
Artificial Joint*			Bloody Sputum			Arthritis		
Ever taken Fen-Phen?*			Emphysema			Hepatitis B or C		
Heart Pacemaker			Tuberculosis			Hepatitis A (infectious)		
Irregular Heart Beat			Cancer			Night Sweats		
Angina/Chest Pain			Radiation Treatments			Drug Dependency		
Heart Attack/Failure			Chemotherapy			Alcoholism		
Congenital Heart Disorder			Stomach/Intestinal Disease			Tattoos/Body Piercing		
High Blood Pressure			Ulcers/Colitis			Stroke		
Bacterial Endocarditis			Rapid Weight Gain/Loss			Epilepsy/Seizures		
Blood Disease			Frequent Diarrhea			Fainting/Dizziness		
Anemia			Diabetes			Glaucoma		
Excessive Bleeding			Excessive Thirst			Psychiatric Care		
Sickle Cell Disease			Hypoglycemia			Nervousness/Anxiety		
Hemophilia			HIV/AIDS			Alzheimer's Disease		
Leukemia			Venereal Disease			Migraines/Headaches		
Recent Blood Transfusion			Genital Herpes			Auto-immune Disease		
Swelling of Limbs			Oral Herpes/Fever Blisters			Need Pre-medication?		
Lung Disease			Yellow Jaundice					

Have you ever had any other serious illness not listed above? If so, please describe

_____

To the best of my knowledge, all the preceding answers are correct. If there are any changes to my health status or medications, I shall inform the dentist and staff at my next appointment.

PATIENT SIGNATURE (PARENT OR GUARDIAN)

X_____ Date _____
mm/dd/yyyy

Reviewed by Doctor (signature) _____ Date _____
mm/dd/yyyy