Patient Registration & Health History

Revised 11/10/16

Patient Information

Email Address: ____________________

Patient Name ____________________ , ____________________ ____ ____________________ ______
Last *First* *M.I.* *Name You Want to Be Called if Different* *Age*

Social Security# ______________ Driver's License# ______________ Gender ☐Male ☐Female Birth Date ______________

Address: ______________ Apt# ______ City ______________ State ______ Zip Code ______

Home # ______________ Work# ______________ Other# ______________ ☐Married ☐Single ☐Child

In case of emergency, contact: ______________ Phone# ______________ Work# ______________

Spouse or Responsible Party Information

The following is for ☐the patient's spouse ☐the patient's parent or guardian Gender ☐Male ☐Female

Name ____________________ , ____________________ ____ ______________ ______________
Last *First* *M.I.* *Social Security #* *Birth Date*

Home# ______________ Work# ______________ Other# ______________ ☐Married ☐Single ☐Child

Employment Information

The following is for ☐the patient ☐the patient's spouse ☐the patient's parent or legal guardian

Employer ______________ Address ______________ City, State ______________

Health History

Reason for today's visit ______________ *Date of last dental visit* ______________ *Former Dentist* ______________

DENTAL HISTORY. Place a mark on Yes or No to indicate if you have had or have any of the following:

Bad Breath	☐Yes ☐No	Blister on lips/ mouth	☐Yes ☐No	Gums Swollen/Tender	☐Yes ☐No	Sensitive to cold/heat	☐Yes ☐No	Sensitivity when biting	☐Yes ☐No
Bleeding/Tender Gums	☐Yes ☐No	Grinding Teeth	☐Yes ☐No	Jaw Pain	☐Yes ☐No	Sensitivity to sweets	☐Yes ☐No	Sores in your mouth	☐Yes ☐No

HEALTH HISTORY. Place a mark on Yes or No to indicate if you have had or have any of the following:

Anemia	☐Yes ☐No	Emphysema	☐Yes ☐No	Hepatitis Type____	☐Yes ☐No	Pacemaker	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Arthritis	☐Yes ☐No	Epilepsy/Seizures	☐Yes ☐No	Herpes	☐Yes ☐No	Pregnancy	☐Yes ☐No	Stroke	☐Yes ☐No
Asthma	☐Yes ☐No	Fainting/Dizziness	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Due Date ______________		Thyroid Disease	☐Yes ☐No
Blood Disease	☐Yes ☐No	Glaucoma	☐Yes ☐No	HIV+/AIDS	☐Yes ☐No	Respiratory Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cancer	☐Yes ☐No	Hay Fever	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No	Tumors	☐Yes ☐No
Chemo or Radiation Tx	☐Yes ☐No	Heart Disease	☐Yes ☐No	Liver Disease	☐Yes ☐No	Rheumatism	☐Yes ☐No	Ulcers	☐Yes ☐No
Cortisone Treatment	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Mental Disorders	☐Yes ☐No	Scarlet Fever	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Diabetes	☐Yes ☐No	Hemophilia	☐Yes ☐No	Nervous Disorders	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No	Other: ______________	

CURRENT MEDICATIONS. *List any medications you are currently taking* ______________

ALLERGIES. I am allergic to ☐Aspirin ☐Barbiturates (sleeping pills) ☐Codeine/Narcotics ☐Iodine ☐Latex ☐Local Anesthetic ☐Penicillin ☐Sulfa ☐Other______________

Whom May We Thank for Referring You?

☐Friend/Relative ☐Flyer/Coupon ☐Insurance Co. ☐Yellow Pages ☐Sign/Walk-In ☐Newspaper______________ ☐Our Employee______________ Other:______________

The answers above are true and correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my health, medications, or other information. I authorize and request my insurance company to pay directly to the dentist/dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance and that any default on my account will be reported to the proper credit agencies. I authorize the use of this signature on all insurance submissions, whether manual or electronic.

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Signature of Patient / Parent / Guardian - *- Date -*