PATIENT REGISTRATION AND HEALTH HISTORY

Please complete the following Confidential Information

You	
	Date:
	Name:
	Spouse/Dom.Partner:
	Address:
	City: State: Zip
	Home Ph #: Cell Ph #:
	Birthdate: SS#:
	Email:
	Married Dom. Partner Single Divorced Widowed

Your Child	
	Date
	Name:
	Address:
	City: State: Zip
	Home Ph # Cell Ph #
	Birthdate: Age: Grade:
	School:

DENTAL INSURANCE
PRIMARY CARRIER
Insurance Co.
Subscriber: DOB:
Union or Local:
Group #
Employee SS# or ID#:
Date Employed:
SECONDARY CARRIER
Insurance Co.
Subscriber: DOB:
Union or Local:
Group #
Employee SS# or ID#:
Date Employed:

ACCOUNT INFORMATION (4)				
Person Financially Responsible For Account				
Name:				
Drivers License #				
How would you like to receive appointment notifications?				
Text	Email	Phone Call at:	Home	Cell
			Work	Other
YOUR:				
Name:				
Occupation:				
Employer:				
Business Address:			City:	State:
Business Telephone:			Ext.	
YOUR SPOUSE:				
Name:				
Occupation:				
Employer:				
Business Address:			City:	State:
Business Telephone:			Ext.	

GETTING TO KNOW YOU (3)	
Referred by:	
Is another member of your family or relative a patient here?	
Their name:	
Person to Contact for Emergency?	
Phone#	
Closest relative not living with you? Name:	
Relationship?	
Phone#	
Address:	
City:	State: Zip:

Please answer all questions.

MEDICAL HISTORY

Have you ever had any of the following?

Yes	No	
		Recent Illness
		Bleeding Tendency
		Diabetes
		Convulsions
		Radiation Treatment
		Monucleosis
		Tumors or growths
		Stroke
		Epilepsy
		Stomach Ulcers
		Sinus Problems
		Anemia
		Phen-Fen
		Sleep Apnea

Yes	No	
		High Blood Pressure
		Hepatitis
		Rheumatic Fever
		Pacemaker
		Heart Trouble
		Heart Murmur
		Kidney Disease
		Liver Disease
		Lung Disease
		Venereal Disease
		Tuberculosis
		HIV or AIDS
		Severe Headaches
		Genital Herpes

Allergy to?

Yes	No	
		Penicillin
		Antibiotics
		Novocaine
		Codeine
		Aspirin
		Barbiturates
		Latex
		Other Allergies
		Need Pre-Medication

Date Signature

Date Signature

Date Signature

Date Signature

Physician's Name:Dr. ______________________________

Yes	No	
		Are you pregnant?
		Do you get short of breath easily?
		Are you taking medication of any kind?

Please list: ______________________________

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DENTAL HISTORY

1 Dental complaint at the moment: ______________________________

2 Date of last dental treatment:_____________ Former Dentist: ___________________________ __________City/St: _____________

3 Has your dental care been REGULAR? _____ IRREGULAR? _______________ INFREQUENT? _____________

4 Approximate date when your teeth were last cleaned: ____________________ Dental x-rays: ______________________

5 Have you ever been treated for gum diseases? ___________________ If so, by whom?_________________________

	Yes	No	
6 Have you ever had your teeth straightened?			Do you wear a retainer? ________________
7 Do your jaws ever feel tired?			..When? ____
8 Clicking or pain in or near your ears?			Do you wear a nightguard?______________
9 Do you clench or 'grind' your teeth?			..When? ____
10 Does food catch between your teeth?			..Where? ____
11 Sensitivity to hot, cold or sweets?			..Where? ____
12 Do you use dental floss?			How many times per week?______________

13 When do you brush your teeth?________________________________

	Yes	No	
14 Do you notice a bad taste in your mouth?			
15 Bleeding gums when you brushing?			
16 Does dental treatment make you nervous?			..Slightly_____ Moderately______ Extremely ______

CONSENT

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) ____ and further authorize and consent that Doctor choose and employ such assistance as she deems fit, I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents of mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient/Parent or Guardian Signature ____ Date_________________________