Registration and Health History
Patient Information

Today's Date: ______________________ Reason for this visit: ______________________

Patient's Name: ____
(Last) (First) (MI)

Address: ______________________ City ______________ State ________ Zip ________

Home # ______________ Work # ______________ Cell # ______________

DOB: ______________ Sex __________

Check appropriate ______ Minor ______ Single ______ Married ______ Separated ______ Divorced ______ Widowed

Employer: ______________________ Email: ______________________

Person to contact in an emergency ______________________ Home # __________ Work # __________

If patient is a minor, give parent or guardian's name ______________________

How did you hear about our office? ______________________

Dental Insurance Information

Insured's Name: ______________________ Relation to patient: ______________________

DOB: ______________________

Insured's Address (if different than above): ______________________

City ______________________ State ______________ Zip ________

Insured's Employer: ______________________ Insurance Company: ______________________

Claims Address:

____

Phone # ______________ Group # ______________ Effective Date of coverage: ______________

Dental History

It is important that we know your medical and dental history. These facts have a direct bearing on your Dental Health. The information is strictly confidential and will not be released to anyone without approval. Thank you for completely filling out this questionnaire.

How long since you have seen a dentist? ________________________ Last complete exam date: __________________________
Date you last had x-rays taken: ________________________________ What is your major dental concern? __________________

Previous Dentist's Name: ____________________________________ City ________________________ State _____________

Y	N	If we could offer you a simple, effective way of whitening your teeth, would you be interested?
Y	N	Do you like your smile?
Y	N	Are you aware of clenching or grinding your teeth??
Y	N	Do you have frequent migraines, headaches, earaches or neck pain?
Y	N	Do your jaw joints (TMJ) pop, click or have a grinding sound?
Y	N	Do you experience pain in your jaw joints (TMJ)?
Y	N	Are your teeth sensitive to hot, cold, sweets or pressure? (circle)
Y	N	Have you had any periodontal (gum) treatments?
Y	N	Do your gums bleed, feel tender or irritated?
Y	N	Have you ever had or been evaluated for orthodontic treatment?
Y	N	Have you ever had a serious/difficult problem associated with any previous dental work?
Y	N	Do you have bad breath or has anyone ever told you that you have bad breath?
Y	N	Do you snore or do you feel tired after a full nights sleep?

Please rank the following in the order in which they would KEEP YOU FROM having dental treatment.

_____Fear of pain _____Lack of Concern _____Cost of Treatment _____Missing Work Time

Medical History

Y	N	Do you have any current health problems? Explain_______________________________________
Y	N	Have you been hospitalized or had serious illness in past 5 years?
Y	N	Are you under a Physician's care now? Explain_______________________________________
Y	N	Substance Abuse?
Y	N	Smoke/chew tobacco?
Y	N	Are you pregnant?
Y	N	Breast Feed?

Family Physician (or OBGYN) ____ Phone # ______________________________
Address ______________________________

List all medications you're currently taking ____

Circle any of the following medications to which you are allergic or have ever reacted adversely.

Aspirin	Penicillin	Sedatives
Codeine	Amoxicillin	Ibuprofen
Local Anesthetic	Sulfa	Metals (any incl. nickel, mercury, etc)
Nitrous Oxide	Latex	Acrylic
Erythromycin	Barbiturates	Other

Check any of the following that you have had or presently have:

___Heart disease or attack
___Stroke
___Transient Ischemic Attack (TIA)
___Chest Pain
___Angina Pectoris
___High Blood Pressure
___Low blood Pressure
___High cholesterol
___frequently tired
___Heart Murmur
___Rheumatic Fever
___Congenital heart failure
___Infective endocarditis
___Mitral Valve Prolapse
___Artificial heart valve
___Heart Valve pathology
___Heart Pacemaker
___Heart Valve replacement

___Heart surgery
___Liver Disease
___Hepatitis A
___Hepatitis B
___Hepatitis C
___Kidney trouble
___Kidney failure
___Kidney dialysis
___AIDS/HIV Positive
___STD
___Blood Transfusion
___Hemophilia
___Bleeding disorder
___blisters
___seizures
___Nervousness
___Emphysema
___Tuberculosis (TB)
___Asthma

___Bronchitis
___COPD
___Repiratory Problems
___Recent weight gain/loss
___Sinusitis
___HERPES
___Hay Fever
___hives
___Cold Sores/fever blister
___Adrenal disease
___Use of steroids
___Cortisone medicine
___Thyroid disease (hypo vs hyper)
___Cancer or Tumor growth
___Leukemia
___Radiation treatment
___Chemotherapy

___Stomach trouble/Ulcers
___Venereal Disease
___Bruise easily
___Cosmetic Surgery
___Glaucoma
___Drug addiction
___Alcoholism
___Osteoporosis
___Arthritis
___Artificial joints (hip, knee)
___Alzheimer
___Anemia
___Pain in Joints
___Psychiatric treatment

Y N Do you have diabetes? If yes, please specify what type ______________________________
Date of diagnosis ______________________________
What was your most recent blood sugar reading? ______________________________
Date last tested______________________________
Recent HBA1C ______________________________

Y N Have you or are you taking any of the following medications (Bisphosphonates) ______________
Aredia Zometa Fosamax Actonel or Boniva?
(If “Yes” please specify dates and reason for taking) from ________ to ________ , for________________)

Y N Have you or are you taking any of the following medications (SSRI)
Lexapro Prozac Paxil Zoloft Luvox Effexor

Have you or are you taking any blood thinner medications, if yes what is your recent INR? ________________
Is there any other medical or dental information or experiences that you feel we should know about? ____________

AUTHORIZATION AND RELEASE

I ceritfy that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered, I understand that providing incorrect inforamation can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsble for payment of all services rendered on my behalf or my dependent.

Patient Signature or Parent/Guardian of child: ______________________________ Date:______________

The information above is true and correct to the best of my belief. I authorize any provider of services to furnish any information requested. I also hereby authorize my Dental Plan Administrator to release or obtain from my organization or person information that may be necessary to determine benefits payable under the group benefits with the Dental Benefit Plan. A Photostat copy of this authorization shall be considered as effective and valid as the original.

I understand that I am responsible for all of the charges for all services rendered to me or any member of my family.

Although I have requested the dentist to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure that the bill is paid within 45 days. If for any reason, my insurance company does not pay any portion of my bill, I further agree to make prompt payment of the bill.

I hereby authorize payment directly to the provider of the dental benefits otherwise payable to me.

Signed ___________________________________ Date