

Patient Number _____ ABC HEALTH HISTORY & REGISTRATION

Patient's Name _____ Sex: M F Birthdate _____ Age _____ Today's Date _____

Home Address _____ City _____ State _____ Zip _____

Previous Address (if less than 3 Years) _____ City _____ State _____ Zip _____

Please Circle One: Single, Married, Separated, Widowed Occupation _____ Home Phone Number _____

Your Employer _____ How Long Employed? _____ Your Soc. Sec. # _____ Work Phone _____

Are you a full time student? Yes No If Patient is a minor we need: Mother's Birthdate _____ Father's Birthdate _____

Name of Spouse (Parent if Minor) _____ Person Responsible For Account _____

Spouse's (Parent's) Employer _____ Spouse's Soc. Sec. # _____ Work Phone _____

Referred to us by _____ EMERGENCY INFORMATION

Reason for this visit _____ Name, Address & Telephone of _____
a Relative Not living with you.

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have a double digit insurance coverage complete this for the second coverage

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

-DENTAL HISTORY-	YES	NO	-MEDICAL HISTORY-	YES	NO
How LONG SINCE you have seen a Dentist?			Do you have any CURRENT HEALTH PROBLEMS?	<input type="checkbox"/>	<input type="checkbox"/>
Last COMPLETE Dental Exam, Date:			Are you under a PHYSICIAN'S CARE now?	<input type="checkbox"/>	<input type="checkbox"/>
Last FULL MOUTH X-RAYS, DATE: <i>(Machine that rotates around your head, or 16 small films.)</i>			For What?		
Are you having PROBLEMS now?	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently taking any medication?	<input type="checkbox"/>	<input type="checkbox"/>
WHAT?			If yes, what?		
Is your present dental health POOR?	<input type="checkbox"/>	<input type="checkbox"/>	Please check yes or no		
Do you wear DENTURES? (Partials or Full)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with your dentures?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease or Attack	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to know more about PERMANENT REPLACEMENTS?	<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>
Have you had BAD dental experiences in the past?	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Are you APPREHENSIVE about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any PERIODONTAL (GUM) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums BLEED, or feel TENDER or IRRITATED?	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with the APPEARANCE of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of GRINDING or CLENCHING your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any HEADACHES, EARACHES, or NECK PAINS?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Do you have LOOSE, TIPPED, or SHIFTING teeth? (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints, (Hip, Knee)	<input type="checkbox"/>	<input type="checkbox"/>
Have you worn BRACES on your teeth? (ORTHODONTICS)	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Do you have DISCOLORED teeth that bother you?	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your smile to LOOK BETTER or DIFFERENT?	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with teeth/fillings BREAKING?	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Do you REGULARLY use DENTAL FLOSS?	<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Would you like us to help you learn proper methods of Home Care, so you can stop dental problems in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	I have reviewed the above medical history section		
Name of Previous Dentist: _____			Are you allergic or have you reacted adversely to any of the following medications?		
City: _____ State: _____			Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
How do you feel about your teeth? _____			Darvon	<input type="checkbox"/>	<input type="checkbox"/>
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.			Nitrous Oxide	<input type="checkbox"/>	<input type="checkbox"/>
FEAR of pain _____ #			LACK of concern _____ #		
COST of treatment _____ #			MISSING work time _____ #		

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. I also understand the use of anesthetic agent embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time service are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____