PATIENT REGISTRATION AND MEDICAL HISTORY

NAME____

___MR ___MRS ___MS ___REV ___DR ___MALE ___FEMALE

___ SINGLE ____ MARRIED ____ DIVORCED ____WIDOWED

PREFERRED NAME____________________________________

D.O.B. ______/______/______ SS# ________/________/__________

ADDRESS ____

CITY ________________________ STATE _____ ZIP __________

HOME#____________________ CELL#__________________

WORK# ______________________ EXT ___________

E-MAIL ______________________________________

EMPLOYER ____________________________________

OCCUPATION __________________________________

WHO REFERRED YOU?

SPOUSE/PARENT NAME_________________________________

D.O.B._____/_____/_____ SS# ________/________/__________

WORK# ___________________________ EXT __________

EMPLOYER____

ADDRESS____

CITY______________________ STATE______ ZIP__________

OCCUPATION_______________________________________

DENTAL INSURANCE

WHO IS RESPONSIBLE FOR ACCOUNT____________________

RELATIONSHIP TO PATIENT____________________________

INSURANCE CO.__________________ GRP#_______________

SECONDARY INSURANCE ____YES ____NO

INSURANCE CO.__________________ GRP#_______________

MEDICAL HISTORY

PHYSICIAN'S NAME______________________ ADDRESS____________________________ DATE OF LAST VISIT ____/____/____

PHARMACY & PHONE NUMBER____

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

____HEART PROBLEMS
____PACEMAKER
____EPILEPSY
____STROKE
____CANCER
____RADIATION /CHEMOTHERAPY
____RESPIRATORY PROBLEMS/ASTHMA
____HEADACHES
____BLOOD DISEASE/ HEMOPHELIA
____HEARING LOSS
___CHEMICAL DEPENDENCY
____PREGNANT- WHAT MONTH_____

____HEART MURMUR/ M.V.P.
____DIABETES
____THYROID DISEASE
____ARTIFICIAL JOINTS/VALVES
____SINUS PROBLEMS
____LOW / HIGH BLOOD PRESSURE
____AIDS/ HIV
____GLAUCOMA
____SNORING/ SLEEP APNEA
____TRAUMA / INJURY TO NECK,HEAD,FACE
____PSYCHIATRIC CARE
____CHOLESTEROL

____CIRCULATORY PROBLEMS
____ARTHRITIS
____EATING DISORDER
____SPECIAL DIET/ DIET PILLS
____RECENT WEIGHT LOSS
____BONE LOSS MEDICATIONS
____ULCERS
____HEPATITUS/ LIVER DISEASE
___VENEREAL DISEASE
____NEUROLOGICAL PROBLEMS
____RHUEMATIC FEVER
____OTHER____________________

MEDICATIONS (please list)____

____

ALLERGIES: ____PENICILLIN ____ASPIRIN/NSAIDS ____CODEINE ____LATEX ____SULFA ____METAL ____IODINE ____AMOXICILLIN ____OTHER____

DENTAL HISTORY

CHIEF DENTAL CONCERN/REASON FOR VISIT ____________________

DATE OF LAST DENTAL EXAM ____/____/____ DATE OF LAST CLEANING ____/____/____ DATE OF LAST X-RAY ____/____/____

TOBACCO USE: _____CIGARETTES _____CIGAR _____CHEW _____PIPE

BRUSHING ___X DAY TEXTURE OF TOOTH BRUSH ________ FLOSSING ___ X WEEK

INTERDENTAL STIMULATORS ____ FLUORIDE ___ TYPE ____________ MOUTH RINSE ___ BRAND ____________

SODA ___ X DAY COFFEE/TEA ___W/ CREAM ___W/SUGAR GUM CHEWING ___X DAY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

___ PERIODONTAL TREATMENT
___ ORTHODONTIC TREATMENT
___ENDODONTIC TREATMENT
___IMPLANTS
___CHEEK BITING
___ UNUSUAL SOUND IN EAR WHEN EATING
___ BLEEDING GUMS- HOW LONG?_____
___ BURNING OF TONGUE
___ FINGERNAIL BITING
___ JAW PROBLEMS
___ BAD BREATH
___ SWELLING /LUMPS IN MOUTH
___ FOOD IMPACTION
___CLENCHING/ GRINDING
___ THUMB SUCKING
___ BLISTERS ON LIP/MOUTH
___ORAL SURGERY
___OTHER ____________________

APPOINTMENTS: A MINIMUM CHARGE MAY BE MADE FOR FAILED OR CANCELLED APPOINTMENTS WITHOUT PRIOR NOTIFICATION OF 24 HOURS. ONCE AN APPOINTMENT IS MADE, PLEASE REMEMBER THIS TIME HAS BEEN RESERVED FOR YOU.

THE ABOVE CONFIRMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. IT IS FOR USE IN DENTAL TREATMENT AND THE BILLING & PROCESSING OF INSURANCE FORMS FOR MY BENEFIT. I WILL NOT HOLD MY DENTIST OR ANY OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGNATURE ____________________ DATE ____/____/____

REVIEWED BY ____________________ DATE ____/____/____

OFFICE USE ONLY:

DATE ____/____/____
CHANGES IN HEALTH HISTORY:

____

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REVIEWED BY ____________________

PT'S SIGNATURE ____________________

DATE ____/____/____
CHANGES IN HEALTH HISTORY:

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REVIEWED BY ____________________

PT'S SIGNATURE ____________________

DATE ____/____/____
CHANGES IN HEALTH HISTORY:

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REVIEWED BY ____________________

PT'S SIGNATURE ____________________

DATE ____/____/____
CHANGES IN HEALTH HISTORY:

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REVIEWED BY ____________________

PT'S SIGNATURE ____________________