REGISTRATION FORM / MEDICAL-DENTAL HISTORY

PATIENT REGISTRATION FOR:_____

Residence Address	
Telephone	Referred By
Other Family Members in the Practice	Preferred Time for Appointments
SSN	DOB / /
Marital Status S M D W	Spouse's Name
If Minor, Name of Guardian	Address & Telephone
Person Responsible for Fee (if other than patient)	Relationship to Patient
Billing Address (if different from above)	
Occupation	Will you receive calls at work?
Employer's Name & Telephone	
EMERGENCY NOTIFICATION Nearest Relative Not Living With You—Name & Telephone	

Medical Alert Sticker

INSURANCE INFORMATION

	Primary Carrier	Secondary Carrier
Name of Insurance Company		
Address		
Telephone		
Subscriber's Name / Relationship to Patient	/	/
Name of Group Policyholder or Union		
Group Policy # / Individual Policy #	/	/
Effective Date / Time Limit for Claims	/	/
Pre Estimate Required	☐ Yes ☐ No	☐ Yes ☐ No
Method of Payment	☐ UCR ☐ Schedule of Payments ☐ Other_____	☐ UCR ☐ Schedule of Payments ☐ Other_____
Coinsurance	Company_____% Patient_____%	Company_____% Patient_____%
Deductible	☐ Yes ☐ No ☐ Individual ☐ Family ☐ Annual $_____ ☐ Lifetime $_____	☐ Yes ☐ No ☐ Individual ☐ Family ☐ Annual $_____ ☐ Lifetime $_____
Plan Covers: Prophylaxis	☐ Yes ☐ No	☐ Yes ☐ No
Orthodontics	☐ Yes ☐ No	☐ Yes ☐ No
Other		

If credit card payment is accepted: Name of Card_____

Card #_____ Expiration Date_____

INSTRUCTIONS:

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office—to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided.

All questions must be answered.

Use the pen supplied by the office.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission To Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

1. Name, address & telephone # of your physician_____

2. Date of last visit to your doctor_____Purpose of visit_____

3. Do you suffer from any disability?_____If yes, describe_____

4. Have you ever, or do you now take illegal drugs?_____If yes, what drugs, and when taken?

   _____*Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.*

5. Do you have AIDS, or are you HIV-positive?_____If yes, describe and provide current status.

6. Do you now have, or have you ever had a venereal disease?_____ If yes, describe.

7. Have you ever had, or do you now have hepatitis?_____ If yes, describe._____

8. For females: Are you pregnant?_____ If yes, when are you due?_____

9. For females: Are you taking birth control pills?_____ *Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*

10. Are you taking any drugs or medications?_____ If yes, list and describe amounts and purpose.

    Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.

11. Have you ever had an allergic reaction to medication?_____ If yes, describe._____

12. Have you lost weight recently?_____ If yes, describe._____

Have You Ever Had Or Been Treated For:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease?_____

14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats?_____

15. Stomach or intestinal disease?_____

16. Abnormal blood pressure, excessive bleeding, or anemia?_____

17. Breathing problems, asthma, tuberculosis, or hay fever?_____

18. Cancer, X-ray treatments, or chemotherapy?_____

19. Diabetes?_____

20. Kidney problems or renal dialysis?_____

21. A stroke, convulsions, or fainting spells?_____

22. Tumors or growths?_____

23. Arthritis or rheumatism?_____

24. Have you ever had a major operation? If yes, describe._____

25. Have you ever had a serious injury to your head or neck? If yes, describe._____

26. Are you on a special diet? If yes, for what reason and describe._____

27. Do you smoke? If yes, describe type and quantity._____

28. Have you consulted or been treated by a psychiatrist, psychologist or counsellor? If yes, describe.

29. Are there any other problems about your health of which you are aware?_____

DENTAL HISTORY

Date of your last visit to a dentist_____

Reason for your last visit (or series of visits)_____

Do you have any of your X-rays or dental records?_____

In respect to any previous dental treatment have you:

30. Ever fainted?_____

31. Had an allergic reaction?_____

32. Had abnormal bleeding?_____

33. Any other complications during or following dental treatment? If yes, describe._____

34. Do your gums bleed on brushing or eating?_____

35. Does food catch between your teeth?_____

36. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose?_____

37. Are any of your teeth sensitive to heat, cold, or pressure?_____

38. Do you grind your teeth or clench your jaws?_____

39. Do you have pain or clicking in the jaw joint around your ear?_____

40. Have your jaw muscles ever been sore? If yes, describe._____

41. Are there any sores or growths in your mouth?_____

42. Do any of your teeth ache?_____

43. Do you have any other dental complaint?_____

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered.

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors, and/or other health practitioners.

Person completing the form: Signature_____

Witness_____ Print Name_____

If other than patient, indicate relationship_____ Date____/____/____

Dentist's History Review & Significant Findings

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Signature Dr._____ Date_____