

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

IF THIS APPOINTMENT IS FOR YOU START HERE			
DATE			
NAME			
SPOUSE			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NUMBER			
DATE OF BIRTH	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NUMBER			
IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE			
DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NUMBER			
DATE OF BIRTH	AGE	MALE	FEMALE
SCHOOL		GRADE	
SOCIAL SECURITY NUMBER			
IF YOUR CHILD'S NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO			

DENTAL INSURANCE	
PRIMARY CARRIER	
INSURANCE COMPANY	
INSURANCE PLAN NAME	
EMPLOYER	
PRIMARY INSURED	
GROUP PLAN	
GROUP NO.	
DATE OF BIRTH	DATE EMPLOYED
SUBSCRIBER ID NO.	
EMPLOYEE SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
INSURANCE PLAN NAME	
EMPLOYER	
PRIMARY INSURED	
GROUP PLAN	
GROUP NO.	
DATE OF BIRTH	DATE EMPLOYED
SUBSCRIBER ID NO.	
EMPLOYEE SOCIAL SECURITY NO.	

ACCOUNT INFORMATION	
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
NAME	
RELATIONSHIP TO PATIENT	
ADDRESS	
CITY	
PHONE NUMBER	
YOU	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS PHONE NUMBER	
YOUR SPOUSE	
NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS PHONE NUMBER	

GETTING TO KNOW YOU	
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
NAME:	RELATIONSHIP
REFERRED TO US BY	
YOUR FORMER ADDRESS	
CITY	STATE
EMERGENCY CONTACT	
PERSON TO CONTACT FOR EMERGENCY	
PHONE NUMBER	
ADDRESS	
CLOSEST RELATIVE NOT LIVING WITH YOU	
PHONE NUMBER	
ADDRESS	
CITY	STATE

Patient Name	Dental/Medical History
Patient Account No.	Medical Alert

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____’s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me an to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Patient Signature_____Date_____

Parent or
Responsible Party_____Relationship to Patient_____

Patient Name	Dental History
Patient Account No.	Medical Alert

WELCOME! So that we may provide you with the best possible care please complete both sides of this medical/dental history form.
All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No
If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
tastes?		
tastes?	Yes	No

Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
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Do your gums bleed or hurt?	Yes	No
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Have your parents experienced gum diseases or tooth loss?	Yes	No
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Have you noticed any loose teeth or change in your bite?	Yes	No
--	-----	----

Does food tend to become caught in between your teeth?	Yes	No
--	-----	----

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
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Bite your lips or cheeks regularly?	Yes	No
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Hold foreign objects with your teeth (penciles, pips, pins, nails, fingernails)?	Yes	No
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Mouth breathe while awake or sleep?	Yes	No
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Have tired jaws, especially in the morning?	Yes	No
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Smoke/chew tobacco?	Yes	No
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Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgury?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause	_____	

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain (joint, ear, side of face)?	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches, or shoulder aches?	Yes	No
Sore mucle (neck, shoulders)?	Yes	No

Are you satisfied with you teeth's appearance?

Would you like to keep all of your teeth all of your life?	Yes	No
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Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern?	_____	

Have you ever had an upsetting dental experience?	Yes	No
If so, please describe	_____	

Is there anything else about having dental treatment that you would like us to know?	Yes	No
If yes, please describe	_____	

(Please complete other side)

Patient Name	Medical History
Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? Yes No
 If yes, for what?
 Physician's Name _____ Phone _____
 Address _____ City _____ State _____ Zip _____

 2. Have you taken any medication or drugs during the past two years? Yes No
 3. Are you taking any medication, drugs or pills now? Yes No
 If yes, please list name and dosage _____

 4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No
 If yes, please list:
 5. Have you been a patient in the hospital during the past five years? Yes No
 6. Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.
- | | | | | | |
|-------------------------------------|--------|--------------------|--------|------------------------------------|--------|
| Heart (Surgery, Disease, Attack) | Yes No | Ulcers | Yes No | Hepatitis A (infectious) B (serum) | Yes No |
| Chest Pain | Yes No | Diabetes | Yes No | Venereal Disease | Yes No |
| Congenital Heart Disease | Yes No | Thyroid Problems | Yes No | A.I.D.S | Yes No |
| Heart Murmur | Yes No | Glaucoma | Yes No | H.I.V. Positive | Yes No |
| High Blood Pressure | Yes No | Contact Lenses | Yes No | Cold Sores/Fever Blisters | Yes No |
| Mitral Valve Prolapse | Yes No | Emphysema | Yes No | Blood Transfusion | Yes No |
| Artificial Heart Valve | Yes No | Chronic Cough | Yes No | Hemophilia | Yes No |
| Heart Pacemaker | Yes No | Tuberculosis | Yes No | Sickle Cell Disease | Yes No |
| Rheumatic Fever | Yes No | Asthma | Yes No | Bruise Easily | Yes No |
| Arthritis/Rheumatism | Yes No | Hay Fever | Yes No | Liver Disease | Yes No |
| Cortisone Medicine | Yes No | Latex Sensitivity | Yes No | Yellow Jaundice | Yes No |
| Swollen Ankles | Yes No | Allergies or Hives | Yes No | Neurological Disorders | Yes No |
| Stroke | Yes No | Sinus Trouble | Yes No | Epilepsy or Seizures | Yes No |
| Diet (Special/Restricted) | Yes No | Radiation Therapy | Yes No | Fainting or Dizzy Spells | Yes No |
| Artificial Joints (hip, knee, etc.) | Yes No | Chemotherapy | Yes No | Nervous/Anxious | Yes No |
| Kidney Trouble | Yes No | Tumors | Yes No | Psychiatric/Psychological Care | Yes No |
7. Do you use more than two pillows to sleep? Yes No
 8. Have you lost or gained more than 10 pounds in the past year? Yes No
 9. Do you have or have you had any disease, condition, or problem not listed? Yes No
 10. If yes, please list:
 11. **Women**, Are you: **Pregnant?** Yes _____ Months No **Nursing?** Yes No
Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review	
Doctor Signature _____	Date _____