PATIENT REGISTRATION & HEALTH HISTORY

Account No. ________________ Date __________

Patient's Name ______________ "Nickname" ______________ Birthdate ____________ Sex ❑ M ❑ F

Patient's Address ______ Street ______ City ______ State ______ Zip ______ Phone ____________

Soc. Sec. No. ____________________ Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

If Employed, By Whom ____ Business Phone ________________

Business Address ____

If Student, Name of School ________________________________ Address ____________________________

Nearest Neighbor or Relative's Name, Address, and Phone No. ____

Who To Call In Case of Emergency ____ Phone ______________

Referred By ____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Responsible Party's Name _________________________________ Birthdate ______________ Sex ❑ M ❑ F

Driver License Number ___________________________________ Soc. Sec. No. _______________________

Street Address (If Diff. Than Above) ______ Street ______ City ______ State ______ Zip ______ Phone ______________

Responsible Party's Employer ____ Years Employed _______

Business Address ____ Phone ____________________

FOR PATIENT'S COVERED BY INSURANCE

Subscriber's Name ____________________________ Birthdate ____________ Soc. Sec. No. ______________

Subscriber's Employer ____ Bus. Phone ______________

Business Address ____

Insurance Company ____ Group No. ______________

Insurance Company Address ____

Insurance Company Phone ____

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Dependent

Are you familiar with your dental insurance? ❑ Yes ❑ No

Are you covered under more than one Dental Plan? ❑ Yes ❑ No

Secondary Insurance

Subscriber's Name ____________________________ Birthdate ____________ Soc. Sec. No. ______________

Subscriber's Employer ____ Bus. Phone ______________

Business Address ____

Insurance Company ____ Group No. ______________

Insurance Company Address ____

Insurance Company Phone ____

Relationship to Patient ❑ Self ❑ Spouse ❑ Dependent

PATIENT MEDICAL HISTORY

Please take the time to answer all the following questions. Your answers are for our records only, and will be considered **confidential.** These facts have a direct bearing on your dental health.

1. Are you in good health? .... YES NO
2. Has there been any change in your general health within the year? .... YES NO
3. My last physical exam was on (approx. date) ____________ .... YES NO
4. Have you been a patient in the hospital during the past two years? .... YES NO
5. Have you been under the care of a medical doctor during the past two years? .... YES NO
   Physician's Name ____________
   Address ____________ Phone No. ____________
6. Have you taken any medicine or drugs during the past two years? .... YES NO
   Are you now taking any medication, drugs or pills? .... YES NO
   If yes, please list____________
7. Are you allergic or have you ever reacted adversely to any of the following medications? .... YES NO

Aspirin	Nitrous Oxide	Valium	Local Anesthetic (Novocaine or Xylocaine)
Darvon	Erythromycin	Motrin	Codeine
Tetracycline	Penicillin	Demerol	Sleeping Pills (Nembutal/Seconal)
Percodan	Other Antibiotics	Latex	

8. Are you aware of being allergic to any other medications or substance? .... YES NO
   If yes, please list____________
9. Circle any of the following which you have had or have at present:

Heart Murmur	Emphysema	H.I.V. Positive
Rheumatic Fever	Cough	A.I.D.S.
Heart Surgery	Tuberculosis (TB)	Hepatitis A (Infectious)
Artificial Joints (Hip, Knee, etc.)	Asthma	Hepatitis B (Serum)
Mirto Valve Prolapse	Hay Fever	Hepatitis C
Heart Failure	Sinus Trouble	Liver Disease
Heart Disease or Attack	Allergies or Hives	Blood Transfusion
Angina Pectoris	Diabetes	Drug Addiction
High Blood Pressure	Thyroid Condition	Hemophilia
Congenital Heart Lesions	X-ray or Cobalt Treatment	Venereal Disease (Syphilis, Gonorrhea)
Scarlet Fever	Chemotherapy (Cancer, Leukemia)	Cold Sores
Artificial Heart Valve	Arthritis	Herpes I or Herpes II
Heart Pacemaker	Cortisone Medicine	Fever Blisters
Anemia	Glaucoma	Epilepsy or Seizures
Stroke	Pain in Jaw Joints	Fainting or Dizzy Spells
Kidney Trouble	Blood Disorders	Nervousness
Ulcers	Sickle Cell Disease	Psychiatric Treatment
Cosmetic Surgery	Bruise Easily	Other____________

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? .... YES NO
11. Do your ankles swell during the day? .... YES NO
12. Do you use more than 2 pillows to sleep? .... YES NO
13. Have you lost or gained more than 10 pounds in the past year? .... YES NO
14. Do you ever wake up from sleep short of breath? .... YES NO
15. Are you on a special diet? .... YES NO
16. Has your medical doctor ever said you have a cancer or tumor? .... YES NO
17. Do you have any disease, condition, or problem not listed? .... YES NO

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No If yes, what month?____________. Are you taking birth control pills? ☐ Yes ☐ No

ABOVE INFORMATION IS TRUE:

Patient Signature ____________ Date ____/____/____

PATIENT DENTAL HISTORY

1. What is your initial concern/or chief dental complaint? ______________________
2. Are you experiencing any pain or discomfort at this time? .... YES NO
3. How long ago was your last dental appointment? ______________ What was done? ______________
4. Previous dentist ______________ Address ______________ Phone ______________
5. When was the last time you had dental x-rays? ______________
6. How often do you have your teeth cleaned? ______________ When was the last time? ______________
7. How often do you brush your teeth? ______________ Floss your teeth? ______________
8. Does food catch between your teeth? ☐ Yes ☐ No If so, where? ______________
9. Do you know extensive destruction of the bone under the gum can take place before the patient is aware of it? .... YES NO
10. Circle any of the following which you have had or have at present:

Bleeding Gums	Oral Surgery	Missing Teeth
Orthodontic Treatment	Implants	Pain in Jaw
Gum Treatment	Frequent Headaches	Trauma to Mouth
Bite Adjusted	Ringing of Ears	Dental phobia/anxiety
Bite Plate	Clicking Jaws	Partial or complete dentures

11. Do you have any problems or dislikes associated with your previous dental treatment? ______________
12. In the past, have you had the opportunity to choose your dental TX or materials such as porcelain, silver or gold? .... YES NO
    If so, what did you choose? ______________

CHOOSE THE ANSWER WHICH BEST DESCRIBES HOW YOU FEEL ABOUT YOUR DENTAL HEALTH

13. My mouth is: a. comfortable b. moderately comfortable c. uncomfortable
14. The appearance of my mouth is: a. excellent b. satisfactory c. unsatisfactory
15. a. I'll do anything to keep my teeth. b. I want to keep them, but I have a certain budget with respect to time and money. c. I really don't care.
16. With respect to my dental health:
    a. I had set goals with my previous dentist.
    b. I have never set goals.
    c. I have not always done what was recommended.
17. When it comes to my dental health:
    a. I have always done what was best.
    b. I have always done what was recommended.
    c. I have not always done what was recommended.
18. I have placed my dental health:
    a. High on my priority list.
    b. Low on my priority list.
    c. It's on my list, but I'm not sure where.
19. I feel my present state of dental health is: a. excellent b. good c. poor
20. I aspire to have my dental health: a. excellent b. good c. poor

RESPONSIBILITY AND CONSENT STATEMENT

I hereby authorize and request the performance of dental services for myself or for ______________ I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by attending dentist or by his supervised staff for diagnostic purposes or dental treatment. These records may include study models, photographs, x-rays, and blood studies.

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient to please check with your insurance company prior to any office procedures. It is your responsibility to know your individual coverage, Please remember your insurance policy is between you and your insurance company and is not between the insurance company and the office. I understand and acknowledge that I am financially responsible for any sevices provided for myself or the above names, regardless of insurance coverage.

I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed for the need for additional treatment,and it's fee.

Responsible Party: ______________ Date: ______________

Signature of Dentist: ______________ Date: ______________

PATIENT INTERVIEW