HEALTH HISTORY & REGISTRATION

Today's Date _____

PATIENT INFORMATION

NAME Last _____ First _____ Middle Initial _____

ADDRESS Street _____ Apt. #_____ City _____ State___ Zip _____

P.O. BOX _____ HOME PHONE _____ WORK PHONE _____

MAILING ADDRESS IF DIFFERENT FROM ABOVE:

_____

SOCIAL SECURITY # _____ BIRTHDATE _____ CELL PHONE _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

RELATIONSHIP TO PATIENT _____

Who May We Thank for Referring You to Our Office? _____ Reason for this Visit _____

PATIENT'S SIGNATURE (Parent if a minor) _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insurance Tel. _____

Insured's Employer _____

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

Insured's Date of Birth _____

DENTAL INSURANCE INFORMATION (Secondary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insurance Tel. _____

Insured's Employer _____

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

Insured's Date of Birth _____

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.

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin	Latex (balloons,
Nitrous Oxide	Codeine	Penicillin	gloves, etc.)

Are you aware of being allergic to any other medications or substances?_____
If yes, please list: _____

Please list all medications you are currently taking.

_____

_____

_____

_____

_____

EMERGENCY INFORMATION:
OTHER THAN SPOUSE

NAME _____ RELATIONSHIP _____
ADDRESS _____
CITY, STATE _____ PHONE_____

Pre-Medicate
Amox Clindamycin
Other

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐

For what? _____

Physician's Name
Telephone No.

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	AIDS/ARC/HIV Pos.	Emphysema
Angina Pectoris	Hepatitis A (infectious)	Tuberculosis (TB)
High Blood Pressure	Hepatitis B (serum)	Asthma
Heart Murmur	Hepatitis C	Hay Fever
Rheumatic Fever	Liver Disease	Sinus Trouble
Congenital Heart	Blood Transfusion	Allergies or Hives
Mitral Valve Prolapse	Drug Addiction	Diabetes
Artificial Heart Valve	Hemophilia (Bleeding Problems)	Thyroid Disease
Heart Pacemaker	Fever Blisters	Radiation Treatment
Heart Surgery	Epilepsy or Seizures	Arthritis
Artificial Joints (Hip, Knee)	Nervousness	PREGNANT
Anemia	Psychiatric Treatment	Depression
Stroke	Glaucoma	Alcoholism
Kidney Trouble	Chemotherapy (Cancer, Leukemia)	Cosmetic Surgery
Ulcers	Bruise Easily	