

HEALTH HISTORY & REGISTRATION

Today's Date _____

PATIENT INFORMATION

NAME Last _____ First _____ Middle Initial _____ Nickname _____

Residential Status Full Time _____ Part Time _____

Local Address _____ City _____ State _____ Zip _____

Out of State Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email _____ Preferred Method of Contact _____

Social Security # _____ Birthdate _____ Sex: Male _____ Female _____

Who is responsible for this account _____ Relationship to Patient _____

Do you have a healthcare surrogate or someone that helps you make decision? Yes _____ No _____

Name of Surrogate _____ Tel. # _____

Whom may we thank for referring you to our office? _____

PATIENT'S SIGNATURE _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insurance Tel. _____

Insured's Employer _____

Insurance ID # _____

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 _____

Insurance ID # _____

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.

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes _____ No _____

Name of physician or dentist making recommendation: _____

Phone: _____

Pre-Medicare

Amox _____ Clindamycin _____

Other _____

EMERGENCY CONTACT INFORMATION:

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY, STATE _____ PHONE _____

MEDICAL HISTORY

YES NO

Do you have any CURRENT HEALTH PROBLEMS? YES NO

Are you under a PHYSICIAN'S CARE now? YES NO

For what? _____

Physician's Name _____

Telephone No. _____

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

Heart Disease or Attack	CVA/TIA (Stroke)	Emphysema
Angina Pectoris	Osteoporosis/Osteopenia	Tuberculosis (TB)
High Blood Pressure	Sexually Transmitted Disease	Asthma
Low Blood Pressure	AIDS/ARC/HIV Pos.	Hay Fever
Heart Murmur	Hepatitis A (infectious)	Sinus Trouble
Rheumatic Fever	Hepatitis B (serum)	Allergies or Hives
Congenital Heart	Hepatitis C	Diabetes Type I or II
Mitral Valve Prolapse	Liver Disease	Thyroid Disease
Pacemaker	Blood Transfusion	Alzheimer's/Dementia
Artificial Heart Valve	Drug Addiction	Eating Disorder
Heart Pacemaker	Hemophilia (Bleeding Problems)	Arthritis
Heart Surgery	Fever Blisters	PREGNANT
Artificial Joints (Hip, Knee)	Epilepsy or Seizures	Depression
Date _____	Nervousness	Alcoholism
Anemia	Psychiatric Treatment	Cosmetic Surgery
Stroke	Glaucoma	Severe Headaches/Migraines
Kidney Trouble	Cancer/Chemotherapy/Radiation	
Ulcers	Bruise Easily	